DHMH 17 Rev 1/2001

ORIGINAL

			For State of N 1 - State Registrar	•	artment of Health and Martificate of Death	lental Hygien	Z 11 11 /	30002
ı	Physicia	an	Decedent's Name (First, Middle, Last)	rt		2. Date of Death Month Da Seplember	ay Year	3. Time of Death 7. 45 PM
	/Medic	al	4a. Facility Name (If not institution, give street and number		4b. City, Town, or Location of Death		County of Death	7. 73
	Examin	er	Ellicott City Nursing & Rehab Co		Ellicott City		Howard	
	Funeral		5. Social Security Number 6. Sex 7. F	ge (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthr	place (State or Foreign ntry)
	Director		577-09-4250 1DM 2DF	8 9 Yrs.		Sept 18 19)17 0	hio
	and and	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Marylan -f ehow	ţō	MD Howard	Columbi	а			1 ☐ Yes 2√ No
	h the	Director	10e. Street and Number		10f. Zip Code	10g. C	itizen of What Cou	ntry?
	23e c	alD	8826 Warm Granite Drive		21045	US		
	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "netural", or Items 23e or 28e-f ehow event. Ite Medical Eraminal must be notified at	Funeral	11. Marital Status 12. Was Deceder Armed Forces	it Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
20	irs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give \(\hat{\Lambda} \) 3 ☐ \(\hat{\Widowed} \) 4 ☐ Divorced Year or Dates	:	1 ☐ Yes 2 ☐ No Specify:		Specify: whi	te
5	'2 hou	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation	ina 16b. I	Kind of Business/Ir	ndustry
7	ithin 7 ne. nen."r	Completed	Eiementary/Secondary (0-12) College (1-40		kind of work done during most of work DO NOT use retired) emaker		domestic	
Maryland Z1Z15-0036	lled Hygi her nt.		17. Father's Name (First, Middle, Last)	Tiom		e (First, Middle, Maide		
ב		o Be	John J. Neuhausel		Virginia	McGrath		
2	d 2 should be f th and Mental h 7 is marked of treumetic ever	2	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Number or Run	al Route Number, City	or Town, State, Zi	p Code)
	2 # Z I		Judy Caton (daughter)		Warm Granite Dr.,			
o Ce	of Healt fitem 2		20a. Method of Disposition 1 □ Burial 2 【③*Cremation 3 □ Removal from Sta	9	matory or other place)	C1-	Location - City or T	
Ě	Pages tment of tent: If it		`4 ☐ Donation 5 ☐ Other (Specify)	All Coun	ty Cremation 9-18-	07	esville,	
baltimore,	permit. Pages Department of Importent: If it any injury or o	l u	21. Signature of Funeral Service Licensee Page Hards Herbert	P	2. Name and Address of Facility Hai .O. Box 195 Sykesy	ght Funera ville, MD 2	ı1 Home & 21784	Chape1
8/00/2	rate be executed // Medical Examiner ithe burial-transit the burial-transit in the buria	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a consequence of): as a consequence of): as a consequence of):	A 12	lar Di	sease	Interval Between Onset and Death
O. Box o	ath certific titending p	Physician/Med		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delin Month	very Day Year
3	uires that the de signed by the a Id be detached f	þ	Part II. Other significant conditions contributing to deat	n but not resulting in the u	underlying cause given in Part I.			the cause of death?
Vital Records,	The law require rate has been si page 2 should b	Completed				24a. Was an autopsy performed?	prior to c death?	topsy findings available completion of cause of
III	ilcien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?		Other	th Check on one		
0	Physic this cral dir	2	1 ☐ Yes 2 ☐ No 1 ☐ Inp. 27. Manner of Death 28a. Date of I		of 28c. Injury at	ome 5 Residence 28d. Describe how in		city)
O	ding th. : After s fune	tlon	1 Natural 5 Pending (Month, 2 Accident investigation	Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
DIVISION OF	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 28e. Place of	Injury - At home, farm, si etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
5	itel or rel Di						(s) and manages	atata d
	Hosp 24 hou Fune stely fi	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basical examiner of the basical examiner on the basical examiner of the basical examiner o	ist of my knowledge, dea s of examination and/or ii stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu-	red at the time, date a	and manner as and place, and due	to the cause(s)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Me	29b. Signature and title of certifier		29c. Licensa number D 3 0 6 4 1 Print) River Neck Roce	29d. [Sej	Date signed (Month	n, Day, Year) 17 207
	W		30. Name and address of person who completed cause of Rame. h Sabapalm: 201-	of death (Item 23a) (Type	River Neck Roa	ad Raltin	nex Mi	enjlar 2/221
•	St Regist	ate trar	31. Date filed (Month, Day, Year) 2007 \$2. Reg	istrar's Signature	whi -			

State of Maryland / Department of Health and Mental Hygien ? 30003 For Stata Ragistrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Vear **Physician** September 8, 2007 10:40 AM <u>Herbert Jones</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Irvington Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☑ M 2 ☐ F Yrs. Director 56 May 11, 1951 213-52-6436 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Examiner must be nutitied at 1 ☐ Yes 2√ No MD Anne Arundel Director Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 701 Glenwood Street 23a 21401 USA Completed by Funeral 12. Was Decedent Ever in U.Sunk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

1 ☐ Yes 2 ☑ No Specify: 14. Race - American Indian, Black, White, etc. unk 1 ☐ Never Married 2 ☐ Married ŏ Baltimore, Maryland 21215-0036 Specify: white 3 ☐ Widowed 4 ☐ Divorced "naturel", the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk Be Pages 1 and 2 should be nent of Health and Mental 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 S. Athol Avenue Baltimore MD 21229
Date 20c. Location City or Town, State t Health Future Care Irvington other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Importent: if it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 MOther (Specify) in State 21. Signature of Funeral Servic Licensee Ronald S. Wane 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director in Baltimore, MD 21201 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Encephalopathy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). The law requires that the death certificate be executed physician and s the burial-transit Exam Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ sign 1 be 1 Yes 2 No 3 Probably 4 Porknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has lirector, page 2 1 Yes 2 or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other. ursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 ☐ No 2 After the funeral 27. Manner of Death

1 Divatural

2 Divatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospitel within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD road Name and address of person who completed cause of death (Item 23a) (Type, Print) Kaymina Miller Main Street Smite 200 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Amend #5 Per FH G871 9/25/07 JH 30004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 6:02 PM EDWARD JOHNSON SEPTEMBER 17 /Medical 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MARYLAND ALTIMORE Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 07-16-9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M M 2□ Days Hours Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at 1 Yes 2 TINo Examiner must be notified Director more 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5 Baltimore "natural", or items 23a Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ 3 Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Norke is marked other 17. Father's Name (First, Middle, Last) 18. Mether's Name (First, Middle Be Peges 1 and 2 should be nent of Health and Mental ohnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or 8 Frank permit. Peges 1 and 2 Department of Health a Important: If Item 27 is (Daughter 21207 Place of Disposition cemetery, cremator 20a. Method of Disposition ö 1 Burial 2 □ Cremation 3 ☐Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt # illure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ISCHEMIC STROKE /Medical Due to (or as a consequence of): Examiner SUBARACHON DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit the death certificate be execu Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was en page 2 autopsy certificate 1□ Yes 2 1No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Minpatient Certification: To 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) \sim AU4176435G17416

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who complete

SEP

KIMBERL

31. Date filed (Month, Day, Year)

GREENE

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 30005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Paul H. Jones Sr Month **Physician** Year 20:57 M 0 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Hours 1 XM 2 □ F 219-40-5118 62 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at MD Baltimore Middle River 1 ☐ Yes 2 No Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 2 any nijury or other traumatic event, the Medical Examiner must be no once. 14 Right Elevator Drive 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify White ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Train Mechanic Marc Train 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Jones Helen Regan ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Jones Jr. / son 4230 Necker Ave. Balto.MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 9/17/07 Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of Funer of Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease shock, or heart failure. I mplications that caused ly one cause on each in he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary tente /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Physician/Medical signed by i Medical Certification: To Be Completed by his certificate has but director, page 2 s

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760%4 hours after death.

-uneral Director: Afely filled in by the fur within 24 hours aff

To the Funeral D

completely filled in

Baltimore, Maryland 21215-0036

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown				23d. Date of delivery Month Day Year
1 1	= pathy affect	ting the	se given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Acute renal	failure	aurtic;	iliac art	24a. Was an autopsy performed?	
25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)	
1 Yes 2 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/0	Outpatient 3☐ DOA	Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	D. Time of Injury M	. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		farm, street, factory, o	ffice	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
29a. Certifier 1 CertifyIng Pl (Check only one) 2 Medical Exa	nysician: To the best of my knowled miner: On the basis of examination and manner stated.	ge, death occurred at and/or investigation, in	the time, date and place my opinion, death occ	e, and due to the cause curred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier			2438 946	(3)	Date signed (Month, Day, Year)
30. Name and address of person who Mohammad S	completed cause of death (Item 23a		iversity	Park A	ve
31. Date filed (Month, Day, Year) SEP 1 9 20	07 32. Registrar's Signature	poste			

A State

Registrar

State of Maryland / Department of Health and Mental Hygiens 0 0 7 30006 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5:40 A.M September 16 2007 Terry Lee Jones /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore 4016 Pennington Avenue If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, May 18, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1₩ 2□F Months Maryland 48 213 76 4919 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Marylenc 10a. State 10b. County or 28e-f show an "naturel", or iteme 23e or 28e-f shov Medical Expressional to multipled at 1 x Yes 2 No Baltimore Maryland N/A **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21226 U.S.A. 4016 Pennington Avenue filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Industrial Maintenance Mechanic 2 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any linjury or other treumatic event QDC8. Be William Farland Jones, Sr. Jeanette A. Berge မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4016 Pennington Avenue Baltimore, Maryland 21226 Brenda Jones / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 9/20/2007 Baltimore, Maryland Cedar Hill Cemetery 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 Part Fator the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final QUAMOUS uen Tas **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an has autopsy 2**X** No certificate 1 Tes 200 No 1 Yes Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Residence 6 Other (Specify) Other: 1 □ Yes Ø No 2 ER/Outpatient 3 DOA 4 Nursing Home 2 this 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification; After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie death (Item 23a) (Type, Print) 30. Name and add 31. Date filed (Month, Day, Year) State 9 Registrar

DHMH 17 Rev 1/2001

Funeral

Director

28a-f show

r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 Is marked other thi any Injury or other traumatic event, the once.

Physician

/Medical

Examiner

nding physician and use as the burial-tran

use

death with the Maryland

Maryland 21215-0036

Baltimore,

Physician /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 5. Social Security Number 217-05-4347 Usual Residence of Decedent Director Maryland 10e. Street and Number Funeral 11. Marital Status Completed by 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) 20a. Method of Disposition 21. Signature of Foneral Service Licenses Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical E FEMALE 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be 2 27. Manner of Death Certification: 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registrar's Signature State Registrar

19

		-	For State Registrar		S	tate of	Marylar		artment o			d Me	ental Hy	giene Reg. No.	1111	7	300	
	Physicia	212	1. Decedent's Name		, Last)							1	2. Date of Do Month	eath Day	Ye	ar	3. Time of 8:35	
	/Medic		Marilyn K							!	i C		9	17	200 County of D		0:33	ам
	Examin	er	4a. Facility Name (If r Hebrew Hot		, give stre	et and num	nber)		4b. City, Tow Rockvi		_ocation of L	eath			ontgo		7	
	Foreset		5. Social Security Nur		6. Sex		7. Age (In yrs.	last birthday) If Under 1 Ye		If Under 24	Hrs.	8. Date of Bi (Month, D	rth	9.	Birthpl	ace (State	or Foreign
	Funeral Director		084-18-88		1 🗆 M	2) QF	84	Yrs.	Months Da	ays	Hours I	Min.	8-4-19	923			yy York	
	pu ,		Usual Residence of D	ecedent 10b. County			10c Ci	ty, Town or L	ocation							10	d. Inside C	ity Limits
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		Completed by Funeral Director	11. Marital Status			Armed For	dent Ever in U	J.S. 13	Was Decedent If Yes, specify	of His Cuban	panic Origin , Mexican, P	? (Spec	rify Yes or N lican, etc.)	0-	14. Race - A Black, V			
26	ours after de al', or Item	γFι	1 ☐ Never Marrie 3 Widowed 4		ied	1 ☐ Yes If Yes, Give Year or Da	2 No		1 □ Yes 2	(No	Specify:				Specify:W	hit	e e	
5	72 hours "natural",	led t	,	15. Deceden	's Educati	on		16a. Dec	edent's Usual O	ccupat	tion	Kmadeim		16b. K	ind of Busin	ess/Ind	ustry	
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č	Ind ZIZI3-0	Соп						Book	keeper		10 Mathada	Nama	(First, Middle					
3	MIRTY INITIA & IX IS-10-0050 Ind 2 should be filed within 72 hours aft the and Mend ellyethen "natural", or 27 is marked other than "natural", or retaumatic event, the Medical Franci	Be	17. Father's Name (F Harry Pin		Last)								kleste		Sumame)			
	Baltimore, Maryiar permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic as once.	ဥ	19a. Informant's Nar	ne/Relations	hip (Type,	Print)		19b. Mai	ling Address (St						r Town, Sta	te, Zip	Code)	
2	and 2		Gail Kurs	h/daug	hter			4531	45th St	t.N	W Wash	ning	ton,Do	200	16			
	Saltimore, bernit. Pages 1 ar Department of Hea mportant: If item any injury or other		20a. Method of Dispo		3 🗆 🗆 🗆	oval from S		Place of Disp cemetery, cr	oosition (Name of ematory or other	of r place)	Da	ate	20c. Lo	cation - City	or To	wn, State	
	Pages ment of ant: If it		'4 □Donation	Other (S	pecify)	OVALISOIN	Che	esapea	ke Crem	ato	ry 9-1	19-2	007	Belt	svill			
-	Dall permit. Depart Import any inj		21. Signature Fun	eral Service	Licensee	_ h	m1328		22. Name and A		-	A	FL 55	n 253 -			0910	series a
1	40244		23a. Part 1. Enter the	e disease, or	complicat	ions that ca	aused the dea		app Fundanter the mode of						L AV.	211	Approxima Interval Be	
	Dissolution		shock, or heart Immediate Cause (F	failure. List inal	only one o	cause on e	ach line.								CT		Onset and	Death
	Physician /Medical		disease or condition resulting in death)		a	Due to (or as a conse	quence of):	ART	~ 1	21117		<u> </u>	11.	_			
	Examiner		Sequentially list con-	ditions.	b	CO	RON	ARY	ART	Tt.	RY	01	SEI	450	7			
,	W B is	Examiner	Sequentially list con- if any, leading to im- cause. Enter Underl Cause (Disease or in that initiated events	nediate ying	ł	Due to (or as a conse	quence of):										
2	xecution and al-tran	xan	that initiated events resulting in death) La	ast	c	Due to (or as a conse	quence of):										
7	If bu , the be executed sysician and he burial-transit	ical E			(d													
-	5 5 4	ed	IE EEMALE.						With	-						-1		
X,	BOX of Bath certification attending for use as	by Physician/M	IF FEMALE: 23b. Was decedent in the past 12 n		23c.	1 Live b	come of pregr inth 2 □ Fet	al death 3	□Ectopic pregr						23d. Date o Month	delive	ry Day	Year
A.	the all	ysici	1 ☐ Yes 2 ☐ 9 ☐ Unknown	No		4∐Pregn 9☐ Unkno	ant at time of	death 5	Other (special	fy)								
- Marine	S, F.	/ Ph	Part II. Other signific	cant conditi	ons contrib	buting to de	eath but not re	sulting in the	underlying caus	se give	n in Part I.		23e. Dio	tobacco	use contribu	te to th	e cause of	death?
- 1	VITAI MECONAS, sician: The law requires t certificate has been signe rector, page 2 should be a		Ĺ	14P	FR	TEN	DEN	V					10	Yes 2	No 3[] Prob	ably 4]Unknown
RSH	aw require s been sig	Completed	VA	Scu	LAR		DEN	EN-	TIA				24a. Wa	is an	24b. Wei	e auto	psy findings npletion of	available cause of
2	The lav	mo											per 1 ☐ Yes	formed?	dea 1 □	th?	2□ No	
3	VITAL P sician: Th certificate rector, pag	Be	25. Was case referre	ed to medica	-					0.4			(Check only					
	OT V Physic	2	1 □ Yes 2 1					ER/Outpati		Othe	4 Nurs		ne 5 Re			Specif	()	
	ding P ding P h. After funer	tion	27. Manner of Death	5 Pendir	'9	(Молі	of Injury th, Day Year)	Injury	M 200.	. Injury Work 1 🔲 Y	:? ′es 2 ∐No		.00. 20001101	J 1.01. 1.1,0	,,			
•	DIVISION I or Attending after death. Director: Afte	fica	2 Accident 3 Suicide	6 Could	not be				street, factory, or	ffice		2	181. Location	(Street al	nd Number	or Aura	l Route Nu	mber,
Č	Safter safter all Direction by the big of th	Certification;	4 🗌 Homicide			bullal	ng, etc. (Spec	:iry)					Oily or 7					
	DIVISION To the Hospital or Attentivition 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only	Certifyii	ng Physic Exemine	ien: To the	best of my kr asis of examir	nowledge, de nation and/or	ath occurred at t investigation, in	the tim	e, date and pinion, death	place, a	and due to the	e cause(s e, date an) and mann d place, and	er as s	ated. the cause	(s)
	the hin 24 the F	Medical	one) 29b. Signature and I			and man	ner stated.		29c. L	icense	number			29d. Da	ite signed (/	Nonth,	Day, Year)	
	To To Corr		250. Signature and	111	300	ill	111	1)		0	018	80	74	SEI	DTEN	BEI	2172	2007
	n		30. Name and addre	ss of person	who comi	pleted caus	se of death (Ite	em 23a) (Typ	e, Print))		1				,
	9		DINESI	4 P	47 E	MI	0612	120	NTROS	E 1	20 K	2Ch	CVILL	EN	10 2	0	852	
		ate	31. Date filed (Monta		2007	32. R	legistrar's Sig	ature	e, Print)		1							
	Regist	rar	2E	L I J	2001	A SK. IM	A CONSTRUCTION	1										

			1 = For State Registrar	State of I	Maryland		artment of F		Mental Hy	giene Rag. No.	/ /	30009
	Physici	an	1. Decedent's Name (First, Mid						2. Date of De Month	Day		3. Time of Death
	/Medic Examin	al	Mark E. Kaca 4a. Facility Name (If not instituti		ər)		4b. City, Town, o	r Location of De			12, 2007 County of Death	8:17 PM ^M
	Examin	E	Northwest Ho	spital Cente	er		Randall	stown		I	Baltimor	e
Ī	Funeral Director		5. Social Security Number 214-76-5379	6. Sex 7. 1 M 2 F	Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		th ay, Year) 195	Cour	place (State or Foreign htry) yland
	σ		Usual Residence of Decedent 10a. State 10b. Coun	ity	10c. City.	Town or Lo	cation					t0d. Inside City Limits
	Maryla	Į.	MD 100. Godin	,		ltimo						1 Yes 2 □ No
	or 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Cou	ntry?
	23a c	ral	5941 Sunset A	venue				1207			USA	
	lteme	Funeral	11. Marital Status 1X Never Married 2 ☐ Ma	12. Was Decede Armed Force arried 1 Yes 2	s?	13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? an, Mexican, Pui	(Specify Yes or No erto Rican, etc.)	D-	14. Race - Americ Black, White,	
Maryland 21215-0036	within 72 hours atter death with the Maryland ene. then "naturel", or tleme 23e or 28e-f ehow he Medical Examiner roust be notified at	þ	3 Widowed 4 Divorce	IT YAS GIVA			1 ☐ Yes 21ሺ No	Specify:			Specify: whi	.te
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75	s withir jiene. r then	σmo	Elementary/Secondary (0-12)	College (1-4)	or 5+)		50 7101 230 731 701	-/		-	janitoria	al
2	al Hyg	Bec	17. Father's Name (First, Middle	le, Last)					ame (First, Middle			
<u> </u>	d Men marke	၉	Steven Joh 19a. Informant's Name/Relation			10h Maili	ng Address (Street		ikay Del			Code)
	nd 2 salth an 27 le r		Marikay Gr				l Sunset					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other thenenaturel; or iteme 23a or 28a-f show envi fulry or other treumatic event, the Madical Examinar must be notified at an once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other-		Cerr	e of Dispo netery, crea	sition (Name of natory or other place	ce)	Date	20c. Lo	ocation - City or To	own, State
Balti	permit. Departrimports eny inju		21. Signature of Prineral Service Ronald	S. Walls Da	rector		Name and Addre tate Ana Saltimore	_		. Ba	ltimore	Street
ı				or complications that cau ist only one cause on eac	sed the death.	Do not en	er the mode of dyir	ng, such as card	iac or respiratory a	arrest,		Approximate Interval Between Onset and Death
7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Aspire		at to	rod boly	s with	asphyz	(IQ		
	Examiner			b.	as a conseque	nce on:						
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•	te be executed ysicien and ie burial-transit	Examiner	Cause (Diseese or injury that initiated events resulting in death) Last	cDue to (or	as a conseque	nce of):						
760,	te be e ysicier ne buri	calE		d								
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P.O. Box	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, pege 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		1 2 ☐ Fetal de t at time of dea	eath 3	Ectopic pregnancy Other (specify)	у			23d. Date of deliv Month	ery Day Year
ď.	s that gred by	by Ph	Part II. Other significant cond	itions contributing to deat	h but not resulti	ing in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco u	use contribute to t	the cause of death?
ord	require	ted							- 10	Yes 2	No 3 Prof	bably 4 Unknown
Division of Vital Records,	2 2 2	Completed			-					opsy ormed?	prior to co	opsy lindings available ompletion of cause of
İ	rtificet	BeC	25. Was case referred to medi	ical				26. Place of D	1 ☐ Yes eath (Check only	one)	1 Yes	2 N o
× >	Physic this ce al dire	ဥ	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inp		NOutpatie		4 Nursing	g Home 5 ☐ Res			fy)
ono	ding P. h. After i tunera	tlon:	27. Manner of Death 1 Natural 5 Pen	dirig	Day Year)	8b. Time o	Wo	ryat rk? ∣Yes 2∭XNo	28d. Describe		ry occurred	Ibalus
Visi	Attending at death. ector: After by the fune	Certification;	3 Suicide 6 □ Cou	ild not be 286. Place of	-	e, farm, st	reet, factory, office			(Street an own, State	nd Number or Rur	al Route Number,
ā	urs after					Hom			Baltim	M, M	oryland	21207
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificete his completely filled in by the funeral director, page	edical		ying Physician: To the be cal Examinar: On the basi and manne	s of examinatio							
	To the To the compl	Me	29b. Signature and title of certi	ifier	\$		29c. Licens	se number		29d. Dat	te signed (Month,	Dey, Year)
		(30. Name and address of person	on who completed cause	eput.	Ba) (Type	DIS	3667		5027	ember 1	4,2007
_			Philip Militel	10, MD 67	rimbl	elt	: II CT. L	ather u	ille, M	0 2	1093	
	Sta Registi		31. Date liled (Month, Day, Ye.	ar) 32. Reg	istrar's Signatu	ге	20		ŧ			
DH	MH 17 Rev 1/2		SEP 19	ZUUI Bearing	1 65 5	LADERAN	E. S.					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. 2.0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Keaton 0250 PM September 11,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Johns Hopkins Falt More
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. V. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, **Funeral** 1 □ M 2 F 213-28-0116 Director WEST VIRGINIA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "neturel", or Items 23a or 28a-f show the Medical Examinar cost be redilled at 10d. Inside City Limits 1 Yes 2 No Director ARUNDEL BROOKLYN MD. ANNE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? AVE 226 31992 SA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) ANNE ARUNDEL CO. College (1-4or 5+) SCHOOL CUSTODIAN 10 permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 Is marked other tt any injury or other traumatic event, Its once. SCHOOL SYSTEM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LILLY OLIVER MEADOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DARLENE DAUGHTER DORIS AVE BALTO. MD. 2122 20a. Method of Disposition 20c. Location - City or Town, State 1 Dourial 2 Cremation 3 Removal from State 9/15/07 GLEN BURNIE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GONCE 21. Signature of Funeral Service Licensee FUNERAL SERVICE P.A. 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RITCHIE HWY. BALTO MD 21225 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardiac Hrrest Dav /Medical Due to (or as a consequence of): Examiner 42 Dairs 21809 Sequentially list conditions, if any, leading to immediate cause. Entail Johning Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the humal transit Division of Vital Records, P.O. Box 68760, thoracto Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🗖 No 1 Tes 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natura 2 Accident 5 Pending 1 Yes 2 No М investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sachin Shrid harani 31. Date filed (Month, Day, Year) 32 (noo North Wolfe Street Baltimorp 32 Begistrar's Signature State Registrar

			1- State of Mar Registrar	ryland / [Department of H Certificate of I	lealth and Me <i>Death</i>	ntal Hygiei Reg.	ne 2007	30011
	Physici /Medio		1. Decedent's Name (First, Middle, Last) John R. Kirby, Jr.				2. Date of Death Month	Day Year	770 (771
>	Examir Funeral		104.005	(In yrs. last bird	Balti	LMOTE If Under 24 Hrs. 8 Hours Min. 8	Date of Birth	4c. County of De. N/A ar) 9. Bi	ath irthplace (State or Foreign Country)
6	Director		Usual Residence of Decedent	70 10c. City, Towr			July 18,	1937 So	Outh Carolina 10d. Inside City Limits
	e Mar 3a-f sh tiffied	Director	Maryland N/A	Balt	imore				1 X Yes 2 □ No
	th with th 23a or 26 Jet be no		10e. Street and Number 5219 - 4th Street		10f. Zip Code 21	225	10g.	Citizen of What C	Country?
5-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Every E		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒No	ispanic Origin? (Speci n, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Am Black, Wh Specify: W	
1215-0	vithin 72 h	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		Decedent's Usual Occup. (Give kind of work done of life. DO NOT use retired Truck Driver	during most of working ()	16b	. Kind of Busines	·
2	filed wii Hygien other th ent, the	e Co	17. Father's Name (First, Middle, Last)		ITUCK DIIVEI	18. Mother's Name (i	First, Middle, Maid		
/lan	2 should be filed and Mental Hygi Is marked other aumatic event, the	To Be	John R. Kirby			Talcie	Standri	dge	
, Mar)	ges 1 and 2 should it of Health and Men If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type. Print) Patricia Kirby / Wife		. Mailing Address <i>(Street &</i> 219 — 4th St				Zip Code) and 21225
Baltimore, Maryland 2121	Pages 1: ment of He ant: If iten ury or oth		20a. Method of Disposition 1 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	cemeter	Disposition (Name of ry, crematory or other place tate Veteran		200	. Location - City o	
Bail	permit. Page Department important: If any injury or once.	l d	21. Signature of Funeral Service Licensee	. la	22. Name and Addres	GOII	ce Funer Baltim	al Servi ore, Mar	ce, P.A. yland 21225
68/60, <	Physician and ph	edical Examiner	23a. Pan1. Enter the disease of complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a display to the condition of the cause). Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a display to the cause of the cause).	consequence o	fominal a			m	Approximate Interval Between Onset and Death Unknown
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ecords, P	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but Hyperical (2)	not resulting in	the underlying cause give	en in Part I.			to the cause of death?
Ť	The ate has page	Completed	<u> </u>				24a. Was an autopsy performed 1 Yes	death?	
X	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	2 PER/Out	tpatient 3 DOA Othe	26. Place of Death (6 er: 4 ☐ Nursing Home		6 DOther (Co	and it
оп ог	nding Phy th. : After this s funeral c	F 16	27. Manner of Death 112 Natural 5 Pending (Month, Day 1) 2 Accident investigation	28b. T	Firme of 28c. Injury		d. Describe how in		есіту)
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	aCT Cutation 6 CT Could not be		rm, street, factory, office	28	f. Location (Street City or Town, St	and Number or F ate)	Rural Route Number,
	ne Hospit n 24 hours ne Funera	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	xamination and	, death occurred at the tin d/or investigation, in my o	ne, date and place, an pinion, death occurred	d due to the cause at the time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)
	To t To tl	Ž	29b. Signature and title of certifier Emerger	uy De	partnent 29c. License	number	29d.	Date signed (Mor	nth, Day, Year)
	(1-1	-	Misasm Phys	ician		D46600	j Sei	Hembo	v 13,2007
	621		30. Name and address of person who completed cause of dea Dr. Dale Barnes 3001 H	ith (Item 23a) ([*] anover		altimore,	Marvland	21225	
ŧ	Sta Registr		31. Date filed (Month, Day, Year) 32. Augistrar' SEP 1 9 2007		forte	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 30012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Robert Lee Kidd, Jr. September 2007 4:20 P. /Medical 4a. Facility Name (If not institution, give street end number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harrford Cc. 847 Federal Hill Road Street If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Hours Months Days 1 X M 2 □ F 218-46-0500 59 Dec. 18,1947 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Harford County Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 847 Federal Hill Road 21154 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 XYes 2□ If Yes, Give Year or Dates: 1 Never Married A Married 2 No 1 ☐ Yes 2 ☐XNo Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor McCommick Company 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Lee Kidd, Sr. Mary C. Drumgoole 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Catherine Kidd (Wife) 847 Federal Hill Road, Street, Maryland 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel Sept.14,2007 | Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — Bel Air 3 Newport Drive Forest Hill, Maryland 21050 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final evebra disease or condition resulting in death) Due to (or as a consequence of): Talignan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Year Day 5 ☐ Other (specify) 1 Yes 2 INo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 2 7No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide

The law requires that the death certificate be executed attending physician and for use as the burial-trar Box 68760% Division or Vital Records, P.O. the been signed by t should be detact page 2 s this certificate To the Hospital or Attending Physician: director, After thi

Examine Physician/Medical þ Completed Be ဥ Certification:

Funeral

Director

28a-f show

7 is marked other than "natural", or items 23a or 28a-f sl traumatic event, the Medical Examiner must be notified

is 1 and 2 should be filed within 72 hours after death vor Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23s

permit. Pages 1
Department of H.
Important: If Iter
any Injury or otf

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: / UX,

> State Registrar

Medical

29b. Signature and title of certifier

9

determined

4 ☐ Homicide

(Check only one)

31. Date filed (Month, Day, Year)

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m. 1) 61

and manner stated.

Registrar's Signature

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

20036

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\begin{align*} \) 30013 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** LLiam 2: 16 AM 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore HOSPITAL Ba Ltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 088-12-3854 1**⊠**M 2□F Director 08-01-Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f shor the Medical Examiner must be notified at 1 Yes 2 No Director N/A MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6807 PARK HEIGHTS AVENUE, #4-C 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No WWII If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🕅 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE δ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN FENCING 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH 1 4 1 KAPLAN SYLVIA **SPIRITUS** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 6807 PARK HEIGHTS AVENUE, #4-C, BALTIMORE, CORINNE R. KAPLAN / WIFE 20b. Place of Disposition (Name of Appropriate CONGREGATION 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State 09/18/2007 4 ☐ Donation 5 Other (Specify) BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Lice SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) eimers **Physician** Severe /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 🔼 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Hospital or Attend 24 hours after death. Funeral Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1🗮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 09-16-2007 Sam, M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
T.N SEIN. M.D 2484 West Belvedere Avenue, Baltimore, MD, 21215

State Registrar

31. Date filed (Month, Day, Year)

SFP

1 9 2007

DHMH 17 Rev 1/2001

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death **Physician** Year 1440 September 2007 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner timore 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ▼ F Months Min Director INIA 10a, State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Director 1 Yes 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 5+5 21218 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 Z No Maryland 21215-0036 1 ☐ Yes 2 No Specify ≥ 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be Warren 1. Hebron 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ante Baltimore, Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses OL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Intra cerebral month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): be executed burial-transit and Box 68760, Due to (or as a consequence of): physician Physician/Medical the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Year Day 5 ☐ Other (specify) P.O. the detached 9□Unknown 9 Unknown 2 signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No certificate has b irector, page 2 s 24a. Was an autopsy perform Division or Vital 2 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P 1 Impatient this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending (Month, Day Year) 1 Natural Injury 5 Pending death. nours after death.

neral Director: / investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral Completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Union Memorial

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Zowie S. Barnes

SEP

Year)

1 9 2007

31. Date filed (Month, Day,

AT 243894

Hospita

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEFMEMBER Pay 18, 2007 02:30AM **Physician** eak /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Center OWSON 8. Date of Birth (Month, Day, Year) D7 10 194 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days DC 1 XM 2 □ F 63 229.56.3772 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Baltimore 1 Yes 2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numb 21212 ane US4 6301 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Decement's obsult occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Docial 12th grade 17. Father's Name (First, Middle, Last) Be ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) Sister Joppa Towson 1000 urdyn 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition Burial 2 Cremation 3 □Removal from State Arbutuo Memonal Baltimore, MD £107 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltmore MD 21212 Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RECURRENT SARCOMA OF LEFT FACE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to lor as a consequence of): Examiner if any, leading to immedit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death n signed by the a Id be detached for 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 1 No 24a. Was an cate has to autopsy perform 2 1∐ Yes ieral Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 1 Natural 2 Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MARYLAND 21204 7601 OSLER DRIVE POH LIM. M. D 31. Date filed (Month, Day, Year) SEP 1 9 2

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend istan 5 per the 8875 1-8-08yt Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** John Mever Lawrence Sr. 18 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Ctr Glen Burnie Anne Arundel 5. Social Security 194 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sev 8. Date of Birth **Funeral** Days 2/5/1921 Vear) Months Hours Min. 11X M 2□ F 214-18-6 86 Director Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show adical Examiner must be notified at Anne Arundel Glen Burnie 1 ☐Yes 2X No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7863 Twin Ridge Drive 21061 Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: white Specify: þ 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Boating Sales Manager Department of Health and Mental Hygis Important: If item 27 is marked other is any Injury or other traumatic event, <u>tr</u> once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Thomas Lawrence Pages 1 and 2 should ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Mr. John Lawrence Jr/son 7863 Twin Ridge Dr Glen Burnie MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/21/2007 Crownsville MD MD Veterans Cemetery H⊟Denation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Meral Service Licenses M01364 Srvc 2nd AveSW Glen Burnie MD 21061 23a. Part1. Enter the list only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) hysician 1 Mmonau /Medical to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last equence of) Examiner that the death certificate be executed ician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending pl IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a a I Inknown 9 Unknown signed by be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probabiy 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has 1∐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1 27. Magner of Death Hospital: Inpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

LAW RENCE

Phys /Me Exar

Funer Direct

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physicia /Medica Examine

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1 - State Registrar		tificate of De		Reg.	No. 2007	30017
icia dic		1. Decedent's Name (First, Middle, Last) JAMES T MOOKE					Day Year 6 200	3. Time of Death
nin		4a. Facility Name (If not institution, give street and number) 514 N. Ellwood Allnue		4b. City, Town, or Loc	cation of Death		4c. County of Dea	f
al or		5. Social Security Number 6. Sex 7. Age (In yrs. las	*/	If Under 1 Year If	Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Bir	thplace (State or Foreign ountry)
		Usual Residence of Decedent 10a. State 10b. County 10c. City, 7	Town or Loc	ation			. , , ,	10d. Inside City Limits
	Director		Balt	imore				1 XYes 2 □ No
	ral Dire	514 N. Ellwood Avenue		10f. Zip Code 212	05	10g.	Citizen of What Co	puntry?
	y Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes, 2 ◯ No If Yes, Give		/as Decedent of Hispa Yes, specify Cuban, M ☐ Yes 2 XNo S	nic Origin? (Spe Mexican, Puerto I pecify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
	Completed by	35 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupation	n nact of workin	16b	. Kind of Business	Industry
	omple	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	sind of work done during NOT use retired)	ig most of workii		Johns Ho	solins
	Be C	17. Father's Name (First, Middle, Last)		18.	h .	(First, Middle, Maid		JACI -
	ဠ	19a. Informant's Name/Relationship (Type. Print)	19h Mailin	Address (Street and		Boute Number Ci	hy or Town State	Zin Cada)
		Pearlie Adams / Sister		V. Ell WOOD		ue Balt		
		1 Burial 2 □ Cremation 3 □ Removal from State	netery, crem	ition (Name of atory or other place)			Location - City or altimor	
ouce.		21. Signature of Funeral Service Licensee				Jun C. GV	cene Fu eMD 212	ireval Svcs
		23a. Part1. Enter the disease, or combications that caused the death. shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
n il		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequent of the		M				20 4245
r	Į.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequentially list conditions)	nce of):					
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Et of underlying Cause (Disease or injury that initiated events resulting in death) Last					12	
		Due to (or as a consequent	nce of):					
	Medical	IF FEMALE:						
	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	eath 3□	Ectopic pregnancy Other (specify)			23d. Date of del Month	lvery Day Year
	ed by Pr	Part II. Other significant conditions contributing to death but not resulting to Death but not resulti		derlying cause given in		23e. Did tobacc		the cause of death?
1	omplet		···			24a. Was an autopsy performed	? death?	utopsy findings available completion of cause of
1	g R	25. Was case referred to medical examiner? Hospital: Hospital:			Place of Death	1 Yes 2 (Check only one)	10 10169	2570
1	on: lo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year)	Outpatient Bb. Time of Injury	28c. Injury at Work?	2	ne 5 Hesidence 8d. Describe how in		cify)
	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home building, etc. (Specify)	e, farm, stre	_		8f. Location (Street City or Town, St	and Number or Ri ate)	ural Route Number,
:	Medical	29a. Certifier (Check only one) 1	edge, death n and/or inve	occurred at the time, destigation, in my opinion	late and place, a	and due to the cause ed at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
:	ME	29b. Signature and title of certifier		29c. License nur			Date signed (Mont	h, Day, Year)
	-	30. Name and address of person who completed cause of death (Item 23	Ba) (Type. P		14670		9 18	2007
		Stephen Sisson GOI N. Carolin	ne S	Veet 7th	Floor Ba	lto. MD	21287	,
tat tra	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Gasal	0				

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MAGNONI LAWRENCE **Physician** SEPTEMBER 14,2007 8:28A™ /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE IVY HALL REHABILITATION CENTER MIDDLE RIVER If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Days Hours 1**⋤** M 2□ F 88 Yrs. MARYLAND 212-18-5851 5-2-1919 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show "natural", or items 23a or 28a-f shoved and examiner must be notified at 1 ☐ Yes 2 No RASPEBURG BALTIMORE MD Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21236 U.S.A. 7911 HILLTOP AVENUE Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: ₩WII Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. WHITE Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced er than "natur t, the Medical B 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LEBO CLOTHING PRESSER 8 n and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (FLORIS) MAGNONI MARIE ANGELO မ or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) if Health 21235 7911 HILLTOP AVENUE MINNIE WICK/SISTER RASPEBURG, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: if ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CATONSVILLE, MD METRO CREMATORY 9-17-07 21. Signature of Funeral Service License 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME ROSEDALE, 1211 CHESACO AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Immediate Cause (Final 150 **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed Exami genvatur that initiated events resulting in death) Last burial-trail Due to (or as a consequence of) physician the burial P.O. Box 68760, Physician/Medical attending ph 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No မ 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Certification: After (Month, Day Year) Injury 5 Pending investigation 1 Natural within 24 hours are. To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D314 (4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 221 M. ENTAW ST Sonte 308 BALTIMONEMD (HASHMI MD 32 Registrar's Signature Year) 31. Date filed (Month, Day, State 1 9 2007 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Sta Regist

	1 - For State Registrar	otato of marylan	Cer	tificate of	Death	10111011111	Reg. No.2007	30019				
on.	1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea	ath Day Year	3. Time of Death				
an cal	ALLAN		M	ONT GOM		SEPTEME	ER 17 200	7 03:20 AM				
er	4a. Facility Name (If not institution, giv			4b. City, Town, or BALTI M	Location of Death	rv.	4c. County of Death					
		HOSPITAL Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h 9 Bi	rthplace (State or Foreign				
	217-72-5787		48 Yrs.	Months Days	Hours Min.	Sept.	1'9 ^{ea} 1958	Country) [VID				
	Usual Residence of Decedent 10a. State 10b. County	10c. Ci ¹	ty, Town or Loc	cation				10d. Inside City Limits				
ctor	Maryland Anne Ar	undel		Pas	adena		1 ☐ Yes 2√ No					
Completed by Funeral Director	10e. Street and Number 7807 Chesapeake	Road		10f. Zip Code	10g. Citizen of What Country? USA							
ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - Am Black, Wh					
by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates:		☐ Yes 21 No	Specify:			White				
etec	15. Decedent's E (Specify only highest gra		(Give I	lent's Usual Occup kind of work done	durina most of work	ting	16b. Kind of Busines	s/Industry				
gm	Elementary/Secondary (0-12)	College (1-4or 5+)	1	oo not use retired Mechaniç	•		Manufactu	rina				
Be Co	17. Father's Name (First, Middle, Last	t)	ļ			e (First, Middle,	Maiden Surname)					
To B	Raymond Mon	tgomery	Shirley	Ph	illips							
	19a. Informant's Name/Relationship	(Type. Print)	į.	-			er, City or Town, State,	•				
	Jean Montgomery	(wife)		Chesapea sition (Name of			a, MD 2112					
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetery, cren	natory or other plac	e) Sept Cem 2	Date 21 007	20c. Location - City o Crownsville					
	4 Donation 5 Other (Specify) Maryland Veterans Cem. 2007 Crownsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122											
-	23a. Part1. Enter the \ sease, or conshock, or heart fail re. List only	plicati that caused the deal			-			Approximate				
	shock, or heart failure. List only Immediate Cause (Final disease or condition	Interval Between Onset and Death 2 HOURS										
	resulting in death)	a. HYPOXIA Due to (or as a conseq	quence of):					& HOURS				
L	Sequentially list conditions.	2 WEEKS										
nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	quence of):									
Medical Examiner	that initiated events resulting in death) Last	cDue to (or as a conseq	uence of):									
cal	•											
Med	IF FEMALE:											
lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnature birth 2 ☐ Feta	aldeath 3	Ectopic pregnancy	1		23d. Date of d Month	elivery Day Year				
ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of c 9□Unknown	jeain 5∟	Other (specify)								
y P	Part II. Other significant conditions	contributing to death but not res	ulting in the un	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?				
ted t						1 🗆 '	Yes 25€No 3□I	Probably 4 ☐Unknown				
Completed by Physician/I				-		24a. Was autor perfo		autopsy findings available completion of cause of				
ပိ	25. Was case referred to medical				26. Place of Deat	1∐ Yes	2 X No 1 □ Ye					
To Be	examiner? 1 ☐ Yes 25 No	Hospital: 1 Inpatient 2 □	ER/Outpatient	t 3 DOA Oth	or:		dence 6 ☐Other (Sp	ecify)				
n: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor			now injury occurred					
catic	2 Accident investigatio 3 Suicide 6 Could not b				Yes 2 ☐ No							
ertifi	4 ☐ Homicide determined		ome, rarm, stre fy)	зет, тастогу, опісе		City or Tov	Street and Number or I vn, State)	Hural Houte Number,				
Medical Certification:		hysician: To the best of my knominer: On the basis of examination and manner stated.										
Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Moi	nth, Day, Year)				
	Nguyen_	, MEDICAL DOC	TOR	RES-	-000	EPTEMBER	MBER 17, 2007					
	30. Name and address of person who				1 1110 -	TREET C	2.4.4.4.2.5					
	31. Date filed (Month, Day, Year)	tNS HOPKINS HOS	PITAL (GOO NORTH	WULTE S	IKEG (B	MUITTORE, M	MKYLHND, 21287				
ite 'ar		2007 A Sur 1	5. 40	अहै।								

			State of Maryland 1 - State Registrer		artment of Hertificate of E			giene 2 0 0	7 30020
	Physici	an	1. Decedent's Name (First, Middle, Last) Mildred Manaels				2. Date of Dea		3. Time of Death
>	/Medic Examin		4a. Facility Name (If not-institution, give street and number)		4b. City, Town or	Location of De		4c. County of	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 2	Hrs. 8. Date of Birth	774/6	Birthplace (State or Foreign
ı	Funeral Director		216161165 10M 200 F 84	Yrs.	Months Days	Hours	Min. (Month, Day 26	1923	Maryland
	yland now		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo					10d. Inside City Limits
	8a-fsh	ector	Maryland Baltimore	Ba	altimore C	County		10g. Citizen of Wha	1 Tyes 2 No
	with th	2	10e. Street and Number 6405 Kenwood Avenue		10f. Zip Code	21237		USA	at Country r
	r death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? n, Mexican, Pu	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Black,	American Indian, White, etc.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show spir injury or other traumatic event, it a Medical Examinar must be inculted at ODGs.	Ď	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No II Yes, Give Year or Dates:		1□Yes 2⊠No	Specify:		Specify:	White
Maryland 21215-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of	working	16b. Kind of Busin	ess/Industry
7121	iene. r then	ompl	Elementary/Secondary (0-12) College (1-4or 5+) N/A		counting			Boumi Te	emple
nd	ould be filed v Mental Hygie wrked other t	Be	17. Father's Name (First, Middle, Last)				Name (First, Middle, ca Ethel So		
ıryla	should nd Men marke imatic	ဥ	John George Jockel 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a		r Rural Route Numbe		ate, Zip Code)
	and 2 saith ar		Bonita E. Conrad (Daughter)				Joppa, Md.		
Baltimore,	ages 1 nt of He : If Item or oth		X X Burial 2 Cremation 3 Chemoval from State		sition (Name of matory or other place	1	Date	20c. Location - Cit	
altin	mit. Pa bertmer cortant injury	- 1	4 Donation 5 Other (Specify) Garce 21. Sonatur of Funeral Service License		of Faith Lassann Add e s Lassann Fü		-22=07 Home	Baltimor	re, Ma.
ä	Depermine Depermine Impo		Worther Joseph		7401 Belai	ir Rd.	Baltimore		
			23a. Part 1. Enter the disease, occumplications that crused the death. shock, or heart failure. List only one cause on such line.	Do not en	ter the mode of dying	, such as car	diac or respiratory ari	rest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) a Due to (or as a cons = ue	nce of):	100				
F	Examiner	ě	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conseque	nce of):					
7.	cuted Ind ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
8760,	death certificate be executed e attending physician and od for use as the burial-transit	Ical Ex	resulting in death) Last Due to (or as a conseque	nce of):					
687	rtificate ng phys as the		IF FEMALE:						
Box 6	leath certifica attending pt d for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 mgpths?	leath 3[Ectopic pregnancy Other (specify)			23d. Date of Month	
Р. О.	res that the de signed by the a be detached f	hysic	1 Yes 2 No 9 Unknown	00					-
	Physicien: The law requires that the this certificate has been signed by the tal director, page 2 should be detached.	Ď	Part II. Other significant conditions contributing to death but not result	ing in the u	nderlying cause give	n in Part I.		./	ute to the cause of death? ☐ Probably 4 ☐ Unknown
Records,	s been si	Completed	De mantie	10			24a. Was a	an 24b W	re autopsy findings available
	ysicien: The lavius certificate has director, page 2	Comp	Caranary Anderry	Did	ease		autop perfor 1 Tes	med? dea	or to completion of cause of th? I Yes 2 7
Vita	sicien: certific irector,	o Be	25. Was case referred to medical Hospital: 1 Inpatient 2 El	R/Outpatie	Othe	-	Death <i>Check only or</i>		(Snacihi)
Division of Vital	ng Phys fter this neral di	\vdash		8b. Time o			-	ow injury occurred	
isio	Attending ir death. ector: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be	e farm st		res 2□No	28f. Location (S	itreet and Number	or Rural Route Number,
<u>≥</u>	s efter	Certification:	4 Homicide determine building, etc. (Specify)	.,,	cot, radioly, dilloc		City or Tow	n, State)	
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know and manner stated.						
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	/	29c. License	number	-	29d. Date signed (Month, Day, Year)
)			· (INomilli)		P DI	9583	5	eptem	ber 15 200
	12		30. Name and address of person who completed cause of leath IV m 2	23a) (Type,	Print) P	WST	reet, ?	Berde	en Manylan
	Sta		31. Date filed (Month, Paly, Year) 32. Registrar's Signatu	re	8				
	Registr	ar	SEP 1 9 2007 Magne	J. A.	mark e				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 007 30021 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:15 AM M 2007 September 7, Ann King Morgan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown 1196 C Luther Drive If Under 1 Year If Under 24 Hrs. Min. Days Hours Min. Dec 18, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 1□M 2√ F 1925 Maryland 81 Director 369-24-4433 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County r than "natural", or Items 23a or 28s-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2√ No Hagerstown Directo MD Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 USA 1196 C Luther Drive Funeral deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 0 administrative secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 end 2 should be fill ment of Heelth and Mental H lant: If item 27 is marked other. Eva Mercy Albert King ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Arlie Morgan/spouse 21740 1196C Luther Drive Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o important: If any injury or ance. 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Roll of Lo 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street un Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Advanced 000 **Physician** months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 D No 3 Ectopic pregnancy Day Month Year 4 Pregnant at time ol death 5 Other (specify) cate hes been signed by the case 2 should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 21210 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 200 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home Sesidence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐XNo 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural 2 Accident s after de-5 Pending 1 Tyes 2 No investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MV 214 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M31. Date filed (Month, Day, Year) SEP 1 9 2007 32. Registrar's Signature Gorden ? State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day William Thomas 9 P MMurphy 14 2007 2:50 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 344 Dogwood Road Millersville Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 11/2/1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 1 M 2 □ F 82 216-16-0785 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Millersville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 344 Dogwood Road 21108 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Metal Refinery 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Thomas Florence Murphy Lavelle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lillian Murphy/wife 344 Dogwood Rd Millersville MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Nation 2 □ Cremation 3 □ Removal from State 9/18/2007 Crownsville MD Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Agneral Sorvice Licenses 2nd Ave SW Glen Burnie MD 21061 Srvcs 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Due to for as a nonsequence offi cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ▼ ○ 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home Pesidence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death

Hygiene.

12 should be filed who and Mental Hygiel 7 Is marked other the

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, I

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division or Vital Records,

To the Hospital or Attending Physician:

the attending physician and hed for use as the burial-tran signed by the a Id be detached f cate has page 2 certificate

Physician/Medical 2 Completed Be P After thi funeral Certification: within 24 hours after death

To the Funeral Director: ...
completely filled in by the f

1 Natural 2 Accident 3 ☐ Suicide 4 ☐ Homicide

29b. Signature and title of certifie

29a. Certifier

Medical

5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 2007

and manner stated.

Registrar DHMH 17 Rev 1/2001

State

State of Maryland / Department of Health and Mental Hygien 2007

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 1502 M Physician 14,2001 moore September Louise /Medical 4c. County of Death 4b. City. Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Ba-Himore The Johns pita Hopkins HOS If Under 1 Year | If Under 24 Hrs.
Months Days Hours | Min 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day 5. Social Security Number 6. Sex 924 South Carolin **Funeral** 1 □ M 2 1 F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location other treumatic event, the Madical Examiner; ust be notified at 1 XYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a Funerai permit. Pages 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural" any injury or other treumatic excessions. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 NO 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ≥ 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) immer 18. Mother's Name (First, Middle, Maiden Sur 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Tyde, Print) Laughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) To Method of Disposition Day 20c. Location - City or Town, State 1 KBurial 2 ☐ Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral ServicesLicense 22. Name and Address of Enter the diffease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart fayl Immediate Cause (Final disease or condition resulting in death) Physician infarction /Medical Due to (or as a consequence of): Examiner 090 exacer bation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit cancel Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 14 years attending pt IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>\$</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No certificate has To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and till of certifier M.D RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Wolfe Street Baltimore, Maryland 21287 Hallowell 600 North 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2007 30024 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 11:45 A. M **Physician** Kenneth K. Miller, Jr. September 13 2007 /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford County Heart Heritage Street If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral ™** M 2□ F 215-32-4770 Maryland 74 Director June 26, 1933 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland Harford County Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21014 8 Colonial Road Items 23a Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature!" ---- any injury or other treasment. Affiled Poices? 1 √Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lanier Engineering Sales 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Craig Kerneth K. Miller, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8 Colonial Road, Bel Air, Maryland 21014 Mrs. Catherine Miller (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Evans Funeral Chapel Sept. 15,2007 Forest Hill, Maryland 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Bel Air
3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licens 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line.

Immediate Cause (Final disease or condition a. Approximate Interval Between Onset and Death **Physician** Menor resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) PSS-S F Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification; To CARE 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide filled tercifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 39889 Sept. 14, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. MACPHAIL RD BEIDIN, MD 21019 DUPPED ANUS 615 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 9 2007

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend #30 Per DVR G871 9/19/07:17 Per DVR G871 9/19/07 9/19/07 9/19/07 9/19/07 9/19/07 9/19/07 9/19/07 9/19/07 9/19/07 9/19/07 9/19/07 9/19/07 9/19/07 9/19/07 9/19/07 9/19/07 9/19/ Reg. No 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 15 2007 Physician 8:00 A M ROSE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE 2013 W. ROGERS AVENUE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 04/10/1919 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** 1□ M 2₩ F NY 88 120-05-9178 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 Ves 2 No Director N/A BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 2013 W.ROGERS AVENUE 21209 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married WHITE 1 □ Yes 2 💢 No Baltimore, Maryland 21215-0036 Specify: <u>ح</u> 3 Widowed 4 □ Divorced "naturai", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) INSURANCE **SECRETARY** rmit. Pages 1 and 2 should be filed w spartment of Health and Mental Hygien portant: If Item 27 is marked other tilly injury or other traumatic event, III w 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HAMMER SOPHIE MAX 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2013 W. ROGERS AVENUE - BALTIMORE, MD 21209 <u>AMY LANGHIRT / DAUGHTER</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 X Removal from State permit. Pages Department or important: If i any injury or once. 09/18/2007 | FLUSHING, NY MOUNT HEBRON 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANGRENE LEFTLEG Physician disease or condition resulting in death) /Medical Due to (or as a consequence of):
PENIPHRAJ UASCURA DISBASZ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the buriaf-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ATRIAL FIBOILLATIEN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed DBNBNTIT 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 → Residence 6 □Other (Specify) 1 🗌 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 Osler DR. Stell Towson MD 21204 Francis X. Carmody 31. Date filed (Month, Day, -Year) State Registrar

DHMH 17 Rev 1/2001

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			1 - For State Registrar		Certificate of De	ath	Reg. No.	
			Decedent's Name (First, Middle, Las			2. Date of De Month	ath Day Year	3. Time of Death
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}	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Loc	eation of Death	4c. County of Death	
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show the Medicul Exertifier must be indiffed at	Completed by Funeral	3 Widowed 4 □ Divorced	Year or Dates:	16a. Decedent's Usual Occupation		16b. Kind of Business/Ir	ndustry
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Ë	should be filed within and Mental Hygiene. s marked other than umatic event, the M	2	19a. Informant's Name/Relationship (7	vna Print)	19b. Mailing Address (Street and		er, City or Town, State, Zi	ïp Code)
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	of Health Item 27	0.0	20a. Method of Disposition	20b. P	lace of Disposition (Name of	Date	20c. Location - City or T	Town, State
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∄	permit. Page Department of Importent: If any Injury or once.		4 □Donation 5 □ Other (Specify		ng Mem P.C. 22. Name and Address of	50ft . 20,2003	MITARIA	(OUN MI)
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			shock, or heart failure. List only	one cause on each line.		don't do del dide of Foophiatory d		Interval Between Onset and Death
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н	/Medical Examiner		resulting in death)					3. 10 -10.5
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x 68	The law requires that the death certificate tite has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	IF FEMALE:	23c. If yes, outcome of pregna	incv		23d. Date of deliv	verv
Вох	ath c ttenc or us	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal	I death 3 ☐ Ectopic pregnancy		Month	Day Year
<u>.</u>	the a	Sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	eath 5 Other (specify)			
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Ö	e law has b je 2 st	ğ				24a. Was		topsy findings available completion of cause of
<u> </u>		5				1 ☐ Yes	2⊠ No 1 Yes	2 No
ita	Phyelcien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Tou.	6. Place of Death (Check only	one)	
<u>~</u>	hyelo nis ce I dire	2	1 ☐ Yes 2 XNo	Hospital: 1 Inpatient 2		4 ☐ Nursing Home 5 ☐ Res		oify)
0	ng PI		27. Manner of Death 1 Statural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury at Work?		how injury occurred	
Ö	endin sath. or: A he fu	atic	2 Accident investigation		M 1 ☐ Yes	2 No		
Division of Vital Records,	l or Atte after de Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factory, office	28f. Location (City or To	(Street and Number or Ru own, State)	rai Houte Number,
	rs aff	Ce						
	To the Hospitel or Attending Phyelcien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Exan	niner: On the basis of examina	wiedge, death occurred at the time, oution and/or investigation, in my opinion	date and place, and due to the on, death occurred at the time,	cause(s) and manner as , date and place, and due	to the cause(s)
	the F iin 24 the F	led	one)	and manner stated.	29c. License nu		29d. Date signed (Month	
	Towith	Σ	29b. Signature and title of certifier	7	25C. LICENSE III		Scotra ibis	14.1007
•	·		the K	I WEN NID	TZE3	100	ا مادر المادر ال	77000
1	1		30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Print) thlan	1 K monas	>	
						E /		
		ate	31. Date filed (Month, Day, Year)	32. gistrar's Signa	ature			
	Regist	rar	3EP 192	UU/ Lagran	Man DO			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 30027 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year WARNER MCWILLIAMS CHARLES 1:30 AM SEPTEMBER 16 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL THE JOHNS HOPKINS Saltimore Under 1 Year If Under 24 Hrs. onths Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 89 138-14-9475 May 28, 1918 New Jersev Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7835 Ellenham Road 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XXVo Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Consultant/Manager Aviation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles McWilliams Alice Hovev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen McWilliams Wife 7835 Ellenham Road Baltimore, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 □Cremation 3 Removal from State Dulaney Valley Mem Gardens 9/20/07 Timonium Maryland Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ignature of Funeral S 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) PNEUMONIA 5days Due to (or as a consequence of): 3 WEEKS BRADYCARDIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequence of): MORTIC 3 YEARS STENIOSIS Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

'natural'

Hygiene.

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 Is marked other than any injury or other traumatic event, the once.

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

attending physician for use as the buria After 1

To the Hospital or Attending Physician: The law requires that the death certificate be executed Director; d in by the within 24 hours aft To the Funeral Di completely filled in

Division or Vital Records, P.O. Box 68760,

Physician/Medical þ Completed Be ို Certification:

O

State Registrar

Medical

25. Was case referred to medical examiner? 1 ☐ Yes 2 💢 No 27. Manner of Death 1 XNatural 2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

and manner stated.

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 TYes

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

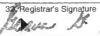
29c. License number RES-000

29d. Date signed (Month, Day, Year) SEPTEMBER 16, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATALIE M BOWMAN. JOHNS HOPKINS LOSPITAL, GOO NORTH WOLFE STREET, BALTIMORE, MAKYLAND 21257

31. Date filed (Month, Day, Year) SEP 1 9 2007



07-07005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mary Ann Nellis State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month **Medical Examiner** 1137 hrs MARY ANN NELLIS September 9, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 248 Persian Road Glen Burnie Anne Arundel 5. Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Months Days Hours Director 1 M 2XXF JUNE 24,1937 NY Yrs 115.28.1767 Usual Residence of Deceden 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yes 2 XX No 28a-f show MD ANNE ARUNDEL GLEN BURNIE notified at once, rector 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? the ō 248 PERSHING AVE. 21061 LISA 238 Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be death Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc 2 XXNo Yes 5 after Widowed 4 X XDivorced f Yes, Give Yes Yes 2 XX No specify: WHITE Specify: ≦ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit, Pages I and 2 should be filed within 72 l Department of Health and Mental Hygiene. event, the Medical marked other than MURSE CAREFIRST 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be REDFIELD BEATRICE DUBBS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 ANNE E. CAOUETTE DAUGHTER 6375 HALLOW WAY, HUNTINGTON, MD 20639 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If it Burial 2 XX Cremation 3 crematory or other place) Removal from State BAYVIEW CREMATORY INC. Donation 5 Other Specific SEP. 12,2007 BALTIMORE, MD 21. Signalu e) f Funeral Service Lic 22. Name and Address of Facility FINK FUNERAL HOME, P.A. CKACORY FINK M01148 CLEN BURNIE 426 CRAIN HWY S 23a. Part I. Enter the disease, or lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval re. List only one cause ch line. Between Onset and /Medical Hypertensive Cardiovascular Disease Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) 4 / 2 cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED attending physician for use as the burial -AMENDED Box 68760, The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death Other (Specify) cate has been signed by the atte page 2 should be detached for a 1 Yes 2 V No 9 Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate ✔ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifit 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Director: 5 Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 10, 2007 30. Name and address of person who completed cause of death (Item 23a) 10 Assistant Medical Examiner Carol Allan, MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, State

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Registra

Registrar

State

31. Date filed (Month, Day, Year)

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completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 30030 For State Registrar Amend 19a, perInf, 0871 9/19/07 TT Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER PA16, 2007 **Physician** 3:38 AM MARGARETT BERNEICE PATRICK /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death Examiner Center lowson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | December 9.1919 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** ILTINOIS 1□ M XXF 160-16-9448 87 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. County 1 ☐ Yes 2 XXVo Director Maryland Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or USA 409 Virginia Avenue 21286 ns 23a must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **2** N No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXXVo Baltimore, Maryland 21215-0036 Specify: Specify: White Completed by XX Widowed 4 □ Divorced er than "nature, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daisy Anglin Joseph Noble 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 08648 19a. Informant's Name/Relationship (Type. Print) DTR 709 Bunker Hill Avenue Lawrenceville New Jersey Daisy Pointing Ponting 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 9/22/07 Parkville, Maryland 5 ☐ Other (Specify) Parkwood Cemetery 4 □ Donation 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 21. Signature of P 6500 York Road Baltimore, Maryland 21212 s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one to Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION **Physician** /Medical Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed HIP FRACTURE attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) uneral director Be Other: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဂ္ After this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Ketwening home from Hospites 1 Natural 5 Pending 1 ☐ Yes 2 ☑ No investigation 107 filled in by the fe 2 Accident 6 Could not be determined 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Street mear nime 24 hours a 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to 🙌 cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie H0041633 30. Name/and address of person who completed cause of death (Item 23a) (Type, Print) 10 TOWSON, MARYLAND 21204 7601 QSLER DRIVE NHOL SEFTER. D. O. C 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2007 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Helen Podmenik September 2007 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) May 29 19 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛛 F 084-26-6565 Yrs May Director 1916 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Mary land 1 ☐ Yes 2 No Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 700 Americana Drive #16 21403 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify þ Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental H Important: If item 27 is marked ot any injuy or other traumatic ever once. Peter Fryc ဥ Mariann Chlibicki 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George P. Hannan 3209 Britannia Court, Annapolis, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. Date 21 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State U.S. Military Academy 4 ☐ Donation 5 ☐ Other (Specify) 2007 West Point, New York 21. Signature of Fun and Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or c molications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of ly inevalue on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) FAILURE Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2ДФю Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 | Yes 2 | No 3 | Probably 4 | No Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 → 1 24a. Was an autopsy performed? Yes 251No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | 100 P 1 Propatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Examiner sician and burial-transit The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 4 physician the as attending | □Se signed by the at if be detached for certificate has treetor, page 2 s To the Hospital or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

28a-f show

23a or

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Examiner must be notified at

Certification:

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide

2001

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier (Check only one)

and manner stated. 29b. Signature/and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

3

erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of

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State Registrar

within 24 hours a

To the Funeral I

completely filled

Medical

31. Date filed (Mor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 09 2007 Thomas H. Pusey /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not inatitution, give street and number) Examiner al-sbure Medical 1/icemico Keylonas eninsula ender Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days Min Hours 1 M 2 □ F 73 Feb 10, 1934 Director 220-28-0640 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at MD Wicomico Salisbury 1 ☐ Yes 2√ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code an "natural", or items 23a or Medical Examiner must be USA
14. Race - American Indian,
Black, White, etc. 532 B Alabama Avenue 21801 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 154–57 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) unk College (1-4or 5+) Elementary/Secondary (0-12) the 12 salesperson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 is marked ott Be thomas H. Pusey Sr Lois Horner 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health 532 B Alabama Avenue Salisbury, MD 21801 Department of Health Important: If Item 27 any injury or other tr once. Dorothy Pusey/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Funeral Service Licensee Ronald S. Wade 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
3 INDIVING Immediate Cause (Final disease or condition resulting in death) Chainma **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown 9 ☐ Unknown cate has been signed by page 2 should be detach ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? very heral 2 No certificate Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 20 10 2 ☐ ER/Outpatient 3 ☐ DOA ဥ After this o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: ospital or Attending hours after death. Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Profifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2007

State Registrar

'n

312 1346 S. DIVISION ST.

SALISBURY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RODNEY

31. Date filed (Month, Day, Year)

SEP

1 9 2007

			For	State of Marylan				d Mental Hy	giene		
			1 - State Registrar		Cei	rtificate of	Death		Reg. No. 2	107	30033
П	Physic	an	Decedent's Name (First, Middle, Last	-				2. Date of De Month	ath Day	Year	3. Time of Death
1	/Medi		Ernest Eugene 4a. Facility Name (If not institution, give	Peacock,	Sr.	4b. City, Town, o	- Laartin f D	Septem		2007	9:25 pm [™]
	Exami	ner	, , , , , , , , , , , , , , , , , , , ,	,			r Location of De	eath		ty of Death	
H	Funeral		1900 Grovemanor Ro		ast birthday)	ESSEX If Under 1 Year	If Under 24 F	Irs. 8. Date of Birt		imore	ace (State or Foreign
'n	Director			\$M 2□F 69	Yrs.	Months Days		in. (Month, Da) 5/22/1	y, Year)	Count	ry)
			Usual Residence of Decedent					5/22/1	930	Mary.	Land
	nylan how l at	_	10a. State 10b. County	10c. City	, Town or Lo	cation				10	d. Inside City Limits
	e Ma 3a-f s tifflec	ç	Maryland Baltimon	re Ess	ex						1 □Yes 2XNo
	with the Maryland a or 28a-f show the notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	ry?
	ath w		1900 Grovemanor Ro			21221			U.S.	Α.	
36	72 hours after death with the Maryland natural", or Items 23a or 28a-f show ilcal Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ★ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give	!	Vas Decedent of H f Yes, specify Cuba I□Yes 2∏ No	ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- lerto Rican, etc.)	14. Ra Bla Speci	ice - America ack, White, e ifv:	
Maryland 21215-0036	72 hours "natural", dical Exa	ed k	15. Decedent's Edu	Year or Dates: (Unkn		lent's Usual Occup	ation		16b. Kind of E	Wh:	ite
215	be filed within 72 ho ital Hygiene. d other than "natu event, the Medical	Completed	(Specify only highest grad	e completed)	(Give	kind of work done of NOT use retired	during most of v	vorking	TOD. KING OF E	iusiness/mu	ustry
212	d within giene. rr than " the Mec	E	9	Coilege (1-4or 5+)	Owner	/ Opera	tor		Restau	ırant	
P	e filed al Hygi other vent, tl	Be C	17. Father's Name (First, Middle, Last)			,		lame (First, Middle,			
/lar	2 should be and Mental is marked camaric ever	일	Unknown	Unknown			Anna	Mae	Peaco	ck	
lar)	2 sho and I is ma	ľ	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailin	g Address (Street	and Number or	Rural Route Numbe			Code)
	12 ji d			K-Wife)	3627	Elmora Z	Avenue	Baltimore	e, Mary	land 2	21213
ore	Pages 1 a nent of Hez int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ F		ace of Dispo: emetery, cren	sition (Name of natory or other plac	e)	Date	20c. Location		
Ë	Pac tant: jury		4 □ Donation 5 □ Other (Specify)		yview	Crematory	7 09/	18/2007	Baltim	ore, N	Maryland
Baltimore,	permit. Pages Department of Important: If i any Injury or one		21. Signature of Funeral Service Licens	ee //	22 B	Name and Addres	s of Facility	ral Home 1	PΣ		
	□ □ = e 0	31 1	Michael CZa	from Sr.	_ 7	407 Old I	Eastern	Avenue 1	Essex.	Maryla	and 21221
			23a. Part1. Enter the disease of compless shock, or heart failure. List only of	ications that caused the death ne cause on each line.	. Do not ente	er the mode of dyin	g, such as card	liac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	myo	and	il my	out	5			Onset and Death
	/Medical Examiner		Tooding in dodain)	Due to (or as a consequ	,		dis				
		į.	Sequentially list conditions,	Due to (or as a consequ	ence of):	astro	dis	eose.			_
	uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	- 40 10 (01 40 4 00110044	01100 017.						
,	icate be executed physician and the burial-transit	Exa	resulting in death) Last	Due to (or as a consequ	ence of):						
38760,	e be sicia e bur	dical	L,	4							
_											
Вох	death certifii e attending p ed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome pf pregnar					23d. Da	ate of deliver	v
o.	0 0	sicia	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnancy Other (specify)			Me	onth E	Day Year
P. O.	at the by th tache	hy	9 □ Unknown	9□Unknown							
	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	by F	Part II. Other significant conditions cor	ntributing to death but not resul	ting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to the	cause of death?
D.C	w requir been si should	ed	peup	rest vasu	en	auseus	4	_ 1 U Y	es 2□ No	3 ☐ Proba	bly 4 ☑ Unknown
Records,	has be	Completed	pen	2 mout	ficie	ny		24a. Was a		Were autop	sy findings available pletion of cause of
E =	The	50	1045	actes me	els 17	0		perfor 1□ Yes	med?	death?	2 No
Vital	y siclan: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					eath (Check only or			
	S S =	ပ္	I Hes ZiX No		R/Outpatient		4 LI Nursing	Home 5 KResid	ence 6 Oth	ner (Specify)	
й	ding Phy h. After thi funeral o	iuo!	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe h	ow injury occur	red	
Sic	ttend death stor:	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	On Place of injury At her			/es 2 □ No				
Division or	or A after of Direct in by	Certification:	4 ☐ Homicide determined	28e. Place of injury - At hon building, etc. (Specify)	ne, rarm, stre	et, ractory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,
	Hospital or Atten 14 hours after death Funeral Director: tely filled in by the		29a. Certifier 1X Certifying Phys	l sician: To the best of my know	ledge death	occurred at the tim	e data and pla	and due to the s	aupe(a) and m		
	24 hose Fun	Medical	(Check only one) 2 Medical Examination	ner: On the basis of examination and manner stated.	on and/or inv	estigation, in my o	pinion, death o	ccurred at the time, o	date and place,	and due to	the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Me	29b. Signature and title of certifier			29c. License	number	2	29d. Date signe	ed (Month, D	ay, Year)
}	0		I morel at	tarono.	MO	D	2809	>	01.7	11-	_
			30. Name and address of person who co	mpleted cause of death (Item.)	23a) (Type. F	Print)	0		-7/1/	0/.	
			RONALY ATTANA	^ . (helad	elphia	Kd. 70.	8 Bal	turar	Md.	21237
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Signatu	ıre	7/20					
	Registr	ar	SEP 1 9 2967	Blacker & B.	A.S.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 4c. County of Death /Medical 4b. City, Town, or Location of Death me (If not institution Examiner 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months Days Min 1□M 200 F 248-42-2049 Usual Residence of Decedent Yrs anc Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medi al Exa<u>miner must be notified at</u> 1 Yes 2 □ No Director more 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify. Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) Callege (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ္ဝ 19a. Informant's Name/Relationship (Type. Print) (niece) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau salto. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Joseph L. Russ

22.72 W. North 21. Signature of Funeral Service Licensee unera Home 23a. Part1 Inter the dis shook or heart failu Immediate Cause (Final disease or condition resulting in death) Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failur **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the a detached 9☐Unknown 9 Unknown by Atter this certificate has been signed I funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 Unknown 1 🗌 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
Injury at 28d. Describe how injury occurred Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) saltimore MD 21201 reene 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

alanda Rogers		State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2007 3	0035
Physicia Vledical Examir	n/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 806 Arnold Court Baltimore	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State Months Days Hours Min.	or
		Usual Residence of Decedent	City Limits
and show any	'n	Do Him on	
eath with the Maryland items 23a or 28a-f show ust be notified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10g. Citizen of What Country?	
death with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, E White, etc.	lack,
p 5 E	<u>a</u>	3 Wildowed 4 Divorced in test, Give their 1 Yes 2 No specify: Specify: Specify: Specify: Specify: 1 Specify: Sp	
5-0036 ed within 72 hours after tygiene. other than "natural", the Medical Exattine	Completed	Elementary/Secondary (0-12) College (1-4 or 5+))()
21215-0036 uld be filed within 7 Montal Hygiene. marked other than	Be Con	11 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	
MD 212 a 2 should b th and Ment a 27 is mark	T P		110
_ = = = = = = = =		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 1 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 1 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 1 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 1 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 1 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 1 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 1 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 1 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 1 Cremation 3 Removal from State 20b. Place 20b. Plac	<u>., O,</u>
Baltimore, permit: Pages 1a Department of He Important: If ite		4 Donation 5 Other Specify: King Memorial Purk 9/24/07 Batter 600 y 21. Signature of Funeral Service Licensee 22. Mame and Address of Facility 22. Mame and Address of Facility 23. Mame and Address of Facility 24. Signature of Funeral Service Licensee	MI
ញ់ ឱ្ង≝្ឋា Physician	- 0	23a. Paft I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximately 1.00 per complex cardiac or respiratory arrest.	ate Interval
/Medical xaminer		lamble. List only one cause on each line.	Onset and eath
	-e-	Sequentially list conditions, b	
H .=	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	-
certificate be executed, certificate be executed, anding physician and use as the burial - transit			
8760, itificate bong physic	n/Med	IF FEMALE: 23b. Was decedent pregnant in the 2b. Was decedent pregnant in the 2ct yet in the pregnant in the pregnant in the pay the pregnancy and pregnancy are pregnancy are pregnancy and pregnancy are pregnancy are pregnancy are pregnancy and pregnancy are pregnancy and pregnancy are pregnancy are pregnancy are pregnancy and pregnancy are pregnancy are pregnancy are pregnancy and pregnancy are pregnancy	Year
Box 6876. He death certificat the attending phy hed for use as the	Physician/Medical	past 12 months? 1 Yes 2 No 9 ✓ Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
, P.O. I			
of Vital Records, P.O. Box is Physician: The law requires that the death often this certificate has been signed by the after metal director, page 2 should be detached for uncal director, page 2 should be detached for uncal	Completed by	24a. Was an autopsy finding autopsy prior to completion of death?	
			No
n of Vital ling Physiciau: After this certif	To Be	1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other: Scene	
Division pital or Attendi ours after death. eval Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route No or Town, State)	ımber, City
D To the Hospital within 24 hours To the Funeral completely filled	Medical C	1 20a Certifier	
To To Corr	Mec		ar)
		O.C.M.E. September 14, 2007 30. Name and address of person who completed cause of death (Item 23a)	
8		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
St Regist	ate rar		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30036 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 2007 8:00 PM Roland Sept 14 R. Lorraine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll Transitions Health Care Sykesville 8. Date of Birth (Month, Day, Ygar) Sept 7 1922 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1 M 2 F 218-12-8846 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Sykesville Carroll MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2324 Erin Road 21784 US Funeral 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant C & P Telephone Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P Charles Raeuchle Lillian Kahler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Roland husband 2324 Erin Road, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place)

S. Carroll Crematory Sept 17 2007 Winfield, Maryland 20a. Method of Disposition 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Burrier-Queen Funeral Home W. Old Liberty Rd., Winfield, MD Part1. I nter the diseas , or complications the shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying I mediate gause (Final dis vase or dondition rest ling in death) **Physician** /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 mo 1 ☐ Yes 2 1 No 9 ☐ Unknown Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an **Director:** After this certificate has in by the funeral director, page 2 prior to comp death? 1 | Yes 2 autopsy perfo To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only of 2 No Hospital: ျ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. within 2. 29d. Date signed Month, Day, 29b. Signature and title of certifier 0 address of person who completed cause of death (Item 23a) (Type, Print) State Registrar DHMH 17 Rev 1/2001

			For State Registrer	State o	f Maryland		artment of I		and Mental Hy	giene 0 0 7	30037
	Physici	an	1. Decedent's Name (First, Middle,						2. Date of De	ath Day Year	3. Time of Death 2 12101P.M.
	/Medic	al	Robert 4a. Facility Name (If not institution,	Donald	Remmey		4b. City. Town.	or Location o	Septemb	4c. County of Dea	
	Examin		Baltimore-Washing			er		Burnie			rundel Co.
	Funeral			5. Sex 112 M 2 ☐ F	7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 2		h 9. Bi	rthplace (State or Foreign
	Director		216-28-0588	1UZM ZLIF	74	Yrs.			March 4	3.0	ryland
	tand • • •		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mary B-f eh	tor	Md. ANNE AF	RUNDEL CO	. G1	en Bu	rnie				1 □Yes 2 ☑No
	ath with the Marylar 23s or 28s-f show	Olre	10e. Street and Number				10f. Zip Code			10g. Citizen of What C	•
	• 23s	rai	226 Wicklow Ave		edent Ever in U.S.	13.1	Mas Decodent of	2106			SA erican Indian.
7 (0	after de or item	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	d 1 ☑ Yes	rces? 2 No				gin? (Specify Yes or No , Puerto Rican, etc.)	Black, Wh	ite, etc.
7	ours a	þ	3 Widowed 4 Divorced	If Yes, Giv Year or D	re ates:		1 ☐ Yes 2 ☐ No	Specify:		Specify: Wh	
EMME 21215-0036	within 72 hours atter death with the Maryland ane. than "nature!", or iteme 23s or 28s-f show he Maylosi Examiner inust be notified at	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual Occu kind of work done DO NOT use retire	during most	of working	16b. Kind of Busines:	s/Industry
77	within iene.	dmo	Elementary/Secondary (0-12)	College (1	I-4or 5+)	<i></i> 0. 1	Electri	,		Const	ruction
C C	be filed tal Hygid d other	BeC	17. Father's Name (First, Middle, La	est)				1	r's Name (First, Middle,	Maiden Sumame)	
ylan		To	William G.	Remmey					rie A. Pfie		7.0.41
Mar	ges 1 and 2 should t of Health and Mer if item 27 is marks or other traumatic		19a. Informant's Name/Relationship						or or Rural Route Number		ZIP Code)
, e	t Health tem 27 tother tra		Lorraine Remmey 20a. Method of Disposition		20b. Pla	ce of Dispo	icklow A sition (Name of matory or other pla		len Burnie,	20c. Location - City o	r Town, State
250m	Pages nent of nnt: if i		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		State	r Hil	1 Cemete	rv	9/17/07	Balto. M	
$\sqrt{3} \frac{8}{12}$	Depertment mportent:		21. Signature of Funeral Service Li	censee	1.	22	. Name and Addr	ess of Facility	Gonce Fune	eral Servic	e P.A.
	402 • d		23a. Part i. Enter the disease	manual omplications that of	aused the death.	41	OOI Ritc	<u>hie Hi</u>	ghway Balt	imore, Md.	21225 Approximate
	Physician		Immediate Cause (Final	nly one cause on e	ach line.			,			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Jue to	(or as a conseque	rice of):	mpoli	7m			
	Examiner	_	Sequentially list conditions,	b							
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a conseque	nce or):					
,	le be executed ysicien and e burial-transit	Exar	that initiated events resulting in death) Last	C. Due to	(or as a conseque	nce of):					
3760,	e × e	Ical		d							
Box 68	ertifica ling pt	Med	IF FEMALE:	22a Musa au	come of pregnance					20101111	P
Bo	eath c attend for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live b	oirth 2 ☐ Fetal d nant at time of dea	eath 3	Ectopic pregnand Other (specify)	су		23d. Date of di Month	Day Year
P.O.	thet the death certifica ed by the attending ph detached for use as th	by Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn							
S, F	es the igned be det	by P	Part II. Other significant condition	s contributing to d	eath but not result	ing in the u	nderlying cause g	iven in Part I.	23e. Did t	obacco use contribute Yes 2 No 3□F	to the cause of death? Probably 4 Unknown
ord	w requir been si should	eted								X	1211 1112
Division of Vital Records,	The law sete has l page 2 s	Completed								prior to rmed? death?	autopsy findings available completion of cause of
ta	ician: Th certificete ector, pag	Be Co	25. Was case referred to medical					26. Place	of Death (Check only of	2 No 1 Ye	s 2 No
Ž	hysician: nis certific I director,	ToB	examiner?			R/Outpatier	IT 3LI DOA		rsing Home 5 🗌 Resi		ecity)
0 10	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending		of Injury th, Day Year)	8b. Time of Injury	We	uryat ork?]Yes 2.∐l		how injury occurred	
isic	Attendideath death octor: A	ficat	2 Accident investiga 3 Suicide 6 Could no	t be 28e. Place	of Injury - At hom	ne, farm, str			28f. Location (Street and Number or I	Rural Route Number,
Š	s after s after si Dire sd in b	Certification:	4 Homicide	buildi	ng, etc. (Specify)				City or To	wn, State)	
	To the Hospital or Attending Physician: The law requires thet the death certifica within 24 hours after death. To the Funeral Director: After this certificete has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier (Check only one) Certifying 2 Medical E	xaminer: On the b	asis of examination	ledge, deat on and/or in	h occurred at the t vestigation, in my	time, date an opinion, dea	d place, and due to the th occurred at the time,	cause(s) and manner a date and place, and do	as stated. ue to the cause(s)
	within 2 To the	Med	29b. Signature and title of certifier	and man	ner stated.		29c. Licer	nse number		29d. Date signed (Mor	nth, Day, Year)
	->-0		Agatas	M			D 4	3977	2	cotembe	11 2007
11	511		30. Name and address of person w	no completed caus	se of death (Item 2	23a) (Type,		114.7	i mo-	2061	
	Sta	ite	31 Date filed (Month, Day, Year)	0 2007 32. F	legistral's Signatu	10	A TO	-w·m	C ,17 W -	-7001	
	Registr		SEP I	9 2007	SALAN .	D. A					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

UNK UNK		- For State Registrar	ate of Marylan		artment of rtificate of		d Menta		Reg	g. 140.		3003
Physicia Medical Examin	n/	Decedent's Name (First, Midd	John Al	bert R:	iggin				Date of Death Month September	Day Year 15, 2007	1	me of Death 154 hrs
¢ .		4a. Facility Name (if not institution 3645 Washington Bo		oer)	4	b. City, Town, or Baltimore	Location of I	Death	L.E.	4c. County of Baltimore		N E
Funeral Director		5. Social Security Number 213 11 7653	6. Sex 7.	Age (In yrs. I	last birthday) Yrs	Months Days		4.0	3. Date of Birth 04/19/	1984	Foreign	e (State or Maryland
w any		Usual Residence of Decedent 10a. State 10b. County Maryland Ann	e Arundel		Town or Locati				:		- 1	Inside City Limits Yes 2 X No
the Maryland	O L	10e. Street and Number 209 Orchard				10f. Zip Code 2122	5		. 10	g. Citizen of Wha	at Country?	
safter death with right, or items 23.	by Funeral		12. Was Deced Armed Ford 1 Yes vorced If Yes, Give Year or Dates:	ces?	If Y	is Decedent of His es, specify Cuban Yes 2 X No	, Mexican, F	uerto Ri	can, etc.)	14. Race - White, Specify: 16b. Kind of Bus	white	
136 thin 72 hour re. than "nata	ompleted	Elementary/Secondary (0-12 8th			during m	ost of working life.						
다 다 다 가 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다	Be C		imothy John	n Rigg:			S	usar	(First, Middle, Maiden Surname) an Frances Sherman			
MD 2121 nd 2 should be 1 alth and Mental m 27 is marke aumatic event	2	19a. Informant's Name/Relation Susan Ruby /		Lanh	209 0	g Address (Stree Prchard A sition (Name of cer	venue	Ba			and 2	1225
2 2 2 2 E		20a. Method of Disposition 1 Burial 2 X Crematic 4 Donation 5 Qther 8	Specify:	n State	crematory or ot ayview (herplace) Crematory	,	09/1	9/2007	Baltim	ore,	Maryland
Baltimo permit. Page Department of Important:		21. Signature of Funeral Service 28a. Part I. Enter the disease, of			40	001 Ritch	nie Hi	ghwa	once Funeral Service, P.A way Baltimore, Maryland			P.A. and 21225
Physician /Medical *xaminer		failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	e on each line. e a. <u>Heroin ir</u>	ntoxicat	ion	пе тюае от аутту,	Such as can	diac of it	espiratory arre	sst, snock, of nea	B	etween Onset and Death
p p	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Last	C	onsequence (of):	ALC:	e try a .	• **	4. 77 -2		450	
0, be executed sician and burial - transi	dical	X UNPENDED	dAMENDED	.28a-f.	perME.g87	71 , 9/27/07	TT					
ision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate redeath. redeath. retor: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the b	žΙ	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 23c. If yes, ou	utcome of preg th nt at time of d	gnancy 2 Fe	etal death 3 ther (Specify)	Ectopic	pregnand	СУ	23d. Date of Month	delivery Day	Year
P.O. E es that the cigned by the detached	Ď	Part II. Other significant cond	itions contributing to	death but not	resulting in the	underlying cause	given in Part	t I.		bacco use contri		eause of death?
of Vital Records, P.O. ng Physician: The law requires that th ther this certificate has been signed by meral director, page 2 should be detach	Completed							_	24a. Was autop perfor	sy p med? d		y findings available letion of cause of 2 No
tal Recident The	Be	25. Was case referred to medic examiner?	[Hospital:		ER/Outpatien		of Death (C			Residence 6 V	Other: Sc	ane
of Viring Physical After this	£.	1 Yes 2 No 27. Manner of Death	28a. Date o	patient 2	28b. Time of		ry at Work?			now injury occurr		3110
sion of attending Pheering Color: After you the funeral	ţi			Day, Year) /15/2007	Fnd 11:5	50 am 1	Yes 2 X	No I	unk			
돌늘특별	1 Natural 5 Natural 2 Natural 2 Natural 3 Suicide 3 Suicide 4 Homicide 4 Secretary 4 Natural 5											
Di To the Hospital within 24 hours To the Funeral completely filled	Medical Co	29a. Certifier 1 Certifying	dge, death occu and/or investiga	rred at the time, d	ate and place n, death occ	e, and d	ue to the caus	e(s) and manner	as stated.			
F. F. S.	Me	29b. Signature and title of certiful Control Control	and manner sta			29c. Licens	M.E.			29d. Date sign September		
		30. Name and address of person Ana Rubio MD. As	ssistant Medical E	xaminer	111 Penn	Street, Baltim	ore, MD 2	21201				
St	ate	31. Date filed (Month, Dan Yea	007 Reg	istrar's Signa	ture	U						

		State of Maryland /						9	
	_	1 - State Registrar	Cer	tificate of I	Death		Reg. No	2007	30039
Physicia	n	1. Decedent's Name (First, Middle, Last)	0	0011111		2. Date of Month	Death Da	y Year	3. Time of Death
/Medica	ıI .	VIRGIE B.		PRINKLE		09	15		
Examine		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		tn		County of Dea	
Funeral		FRANKLIN SQUERE HOSPITAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last)	birthday)	If Under 1 Year	If Under 24 Hrs		Birth	ALTIM 8	hplace (State or Foreign buntry)
Director		578-14-9730 1□M 3€ 87 Usual Residence of Decedent	Yrs.	Months Days	Hours Min	. (Month, 5-13	Day, Year -192	0 MA	RYLAND
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	10a. State 10b. County 10c. City, To BALTIMORE	own or Lo		SEDALE				10d. Inside City Limits 1 □Yes 2 No
ifter death with the Mar r items 23a or 28a-f st liner must be notified	al Dire	10e. Street and Number 8040 PHILADELPHIA ROAD		10f. Zip Code	1237		10g. Ci	tizen of What Co U	.S.A.
ems :	iner.	11. Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Specify Yes or	No-	14. Race - Ame	
ral", or it	2	1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	- 1	1 ☐ Yes 2√☐ No	Specify:	ito i iloan, etc.,		Black, Whit	WHITE
72 h "natu dical	3	15. Decedent's Education 16 (Specify only highest grade completed) 1	Sa. Deced (Give	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of wo	rking	16b. K	ind of Business/LTIMORI	Industry
within ene. than re Me	palaidilloo	Elementary/Secondary (0-12) College (1-4or 5+)		00 NOT use retired ETERIA	1)		- 1		SCHOOLS
filed Hygis	3 . u	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Midd	_1		
2 should be fill and Mental H is marked out aumatic even	2	TOBY DECATUER			EMMA		(:	LEE)	
d 2 sh th and 7 is n traun				g Address (Street a					
1 and Health tem 27 other tr	1			PHILAD]		Date		Ocation - City or	, MD 21237
Pages ment of H ant: If its ury or of		Todala 2 Dolemation 3 Diremoval nom State		sition (Name of natory or other plac OF FAI'				LTIMORI	,
permit. Depart Import any inj		21. Signature of Funeral Service Licensee			ss of Facility CV SACO AV		OSEDA:		NERAL HOME 21237
3	I	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not ente	er the mode of dyin	g, such as cardia	c or respirator	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	LAS	Inse	nctio	N		2	Onset and Death
/Medical Examiner	i	resulting in death) Due to (or as a consequence)	e of):	~ · ·	-				
6		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence)	- A.	Buter	cal F	Siser	se		
executed in and ial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events).	-					
te be executed ysician and the burial-transit	- > 0	that initiated events resulting in death) Last c. Due to (or s a consequence	e of):	ON					
se be	<u> </u>								
tificate ng phy as the									
The law requires that the death certificate be executed the has been signed by the attending physician and sage 2 should be detached for use as the burial-transition moleted by Dhysician Madrical Exami	yalolaliyi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ To 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)				23d. Date of del Month	ivery Day Year
that the ed by detac		Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause give	en in Part I.	23e. Di	d tobacco	use contribute to	the cause of death?
w requires that the d been signed by the should be detached						1[Yes 2	□ No 3□ Pr	obably 42Unknown
: The law requi						24a. Wa	as an topsy rformed?	24b. Were au prior to death?	topsy findings available completion of cause of
		25. Was case referred to medical				1□ Yes	2 2 No	1 ☐ Yes	2 □ No
Physician: r this certific ral director,	í	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 PER/C	Dutnatient	3 DOA Othe	26. Place of De			a □0th/0	- 14. A
ding Physical After this continued din		27. Manner of Death 28a. Date of Injury 28b	. Time of	28c. Injury Work		28d. Describ		6 □Other (Spec ry occurred	ыту)
Attending r death. ector: After by the funer		1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury		<br Yes 2 □ No				
rs after death. rs after death. ral Director: After led in by the funers		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office			(Street ar own, State		ral Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu Medical Certification		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled and manner stated.	ge, death and/or inv	occurred at the timestigation, in my op	ne, date and plac pinion, death occ	e, and due to thurred at the tirr	ne cause(s e, date an) and manner as d place, and due	stated. to the cause(s)
Vithin within Comp		29b. Signature and title of certifier		29c. License	number	7	29d. Da	te signed (Monti	n, Day, Year)
6	-	30. Name and address of person who completed cause of death (Item 23a		. ^	3310	<u> </u>		4/18/0	7
State		Tide Wineses MD 7845 (31. Date filed (Montgop Year) 9 2007 32. Registrar's Signature	DAF	wood ko	ad C	olen B	ol,W'.G	MIZ	21061
Registrar				-					

Physicia /Medic Examin	al	1. Decedent's Name (Ned Hobso 4a. Facility Name (If n	n Sine J	(r		Cel		0.00	attion of Death	2. Date of De Month Septemb	ath Day	Y	ear	3 0 0 4 3. Time of Deat 9:32 AM
uneral irector		326 Leitc 5. Social Security Num	nbeunk 6. So	FILE OF F	e (In yrs. I	as <i>t birthday)</i> Yrs.	If Under 1	Year If U	Landing Inder 24 Hrs. Durs Min.	8. Date of Bir (Month, Da			Birthpla Countr	e1 ce (State or For y) Virgini
wor.		Usual Residence of D 10a. State	Ob. County		10c. City	, Town or Loc	cation						100	d. Inside City Lin
8a-fe	Director		Anne Aru	nde1		[racy's								1 ☐ Yes 2
like D		10e. Street and Numb					10f. Zip C		770			zen of Wha	it Countr	y?
"natural", or items 23a or 28a-f show idical Examiner must be nullified at	by Funeral	11. Marital Status 1 Never Married 3 Wildowed 4	I 2⊡ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 M If Yes, Give Year or Dates:			Vas Deceder Yes, specifi	nt ol Hispan y Cuban, Me	779 ic Origin? (Spexican, Puerto ecify:	pecify Yes or No Di Rican, etc.)		JSA 14. Race - Black, \ Specify:	America White, et	C.
then "natural", he Madical Exc	Completed	(Specify Elementary/Second		de completed) College (1-4or 5	+)	16a. Deced (Give) life. D	lent's Usual kind of work DO NOT use disab	done during retired)	most of work	king		nd of Busin	ess/Indu	stry
d other then event, the Ma	Be Co	17. Father's Name (Fi		unk				18. 1	Mother's Nam	e (First, Middle,				
	10 B	Ned Hobso	n Sine S	Sr					Jess:	ie Dale	Funk			
27 le m r traum	g	19a. Informant's Nam Jane	e/Relationship (7 Ho1den/f	• • • • • • • • • • • • • • • • • • • •		19b. Mailin	g Address (S	Street and N	lumber or Rui	ral Route Numbe	er, City o	r Town, Sta	ite, Zip C	code) t
important: If tem eny injury or othe once.		4 Donation 5	Cremation 3 ☐	Removal from State	20b. PI	ace of Dispos metery, crem	natory or oth	er place)	1	Date		cation - Cit	,	
eny in		21. Signature of Fund ROI		Wine Dire	ctor	St Ba	Name and ate Arallitimor	Address of I	Facility Board 2120	655 W.	Ba1	timor	e St	reet
physicien and physicien and sthe burial-transit	edical Examiner	resulting in death) Sequentially list condition, leading to immicause. Enter Underly Cause (Disease or in) that initiated events resulting in death) Las	ediate ing ury	a. Due to (or as: Due to (or as: Due to (or as:	a consequ	enca or):	510	D						
O 0	Physician/Med	IF FEMALE: 23b. Was decedent printhe past 12 mo 1 Yes 2 N 9 Unknown	onths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetel	death 3 🗌	Ectopic preg Other (spec				2	3d. Date o Month		ay Year
signed b	Ď	Part II. Other significa	ant conditions co	ontributing to death be	ut not resu	lting in the un	derlying cau	se given in I	Part I.	23e. Did t		No.		cause of death?
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is certi	To Be	25. Was case referred examiner? 1 Tes 2 No	1	Hospital: 1 ☐ Inpatie	nt 2 🗆 E	R/Outpatient	3□ DOA	I a.		h (Check only o		Other (Specify)	
r: After the funeral		27. Manner of Death 1 Natural 2 Accident	5 ☐ Pending investigation	28a. Date of Injur (Month, Day	Year)	28b. Time ol Injury		: Injury at Work? 1 Yes		28d. Describe			//	
el Directo ed in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injubuilding, etc	iry - At hor :. (Specify)	ne, farm, stre	et, lactory, o	office		281. Location (S City or Tox	Street and vn, State,	d Number o	or Rural I	Route Number,
he Funer	edical	29a. Certifier 1 (Check only 2 one)	Certifying Phy Medical Exam	ysician: To the best of liner: On the basis of and manner sta	examinati	rledge, death on and/or inv	occurred at estigation, in	the time, da	te and place, death occur	and due to the red at the time,	cause(s) date and	and manne place, and	er as stat	ed. ne cause(s)
To t comp	W	29b. Signature and titl	e of certifier	P		2,00	29c. t	icense num	ber (205	4 Side	29d. Date	e signed (A	fonth, O	y, Year)
	1			7		W /				•	- /	/	' ' -	•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Z8 PM errie Stago September 200 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and rhumber) 4b. City. Town, or Location of Death Examiner Baltimor ndallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. Month, Day Vorthwest Birthplace (State or Foreign Country) 6 Sex Age (In vrs. last birthday) **Funeral** 2 1 □ M 2 □ **V**F Director inia dence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show ust be notified at 1 Xes 2 No Director DMOI 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code must h Funeral Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Items 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or Items edical Examiner m Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 □ Yes 2. XVNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumation. 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surnam Be band 19b. Mailing Address (Street and Number or Rural 19a. Informant's Name/Relationship (Type. Print) Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name 20a. Method of Disposition 1 Burial 2 □ Cremation 5 Other (Specify) 4 ☐ Donation 21. Signature of Funeral Service Licensee 23a. Par J. Enter the dijlease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, str., or heart failure. List only one cause on each line. Approxi-Interval Between Onset and Death Imme are Cause (Final diseas or condition resulting in death) Pur Monura Due to (or as a consequence of). **Physician** ISM /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-trar Due to (or as a consequence of): attending physician Physician/Medical as the l 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a Records, P.O. 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□ No 1 ☐ Yes Division or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be PENO Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

le

State Registrar

DHMH 17 Rev 1/2001

5401 old Court

Randalistan Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2007

32. Registrar's Signature

Edelman

31. Date filed (Month, Day, Year)

			For State of Maryla 1 - State Registrar	-	artment of F rtificate of I		/lental Hy	giene Reg. N	007	30042
16.	Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of De			3. Time of Death
ř	Physicia /Medic		Helen A. Schuchhardt				Septembe	r 18	2007	12:15A ^M
¥ 30	Examin	er	4a. Facility Name (If not institution, give street and number) Riverview Nursing Cente	<u>_</u>		r Location of Death		4C.	County of Deat	
<u>برايد</u> د (اد	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	L s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth		imore hplace (State or Foreign
10	Director			84 Yrs.	Months Days	Hours Min.	April	30, 1	1923 M	aryland
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. County	City, Town or Lo	cation					10d. Inside City Limits
	Maryl -f sho fied a	tor	Maryland Baltimore	Bal	timore					1 □Yes 2 No
	h the or 28a s notifi	Director	10e. Street and Number		10f. Zip Code			10g. Citi	zen of What Co	ountry?
	23a c		917 Cold Spring Road		2122					Of America
386	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 1 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in I Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	'	Was Decedent of H f Yes, specify Cyba 1 ☐ Yes 22 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)	0-	14. Race - Ame Black, Whit Specify:	
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2	vithin ne.	mple	Elementary/Secondary (0-12) College (1-4or 5+)	life. L		during most of worl	9			
d 21	be filed within 72 ho ital Hygiene. d other than "natur event, the Medical.	ပ္ပ	12 N/A 17. Father's Name (First, Middle, Last)		HOM	emaker 18. Mother's Nam	ne (First, Middle	, Maiden		ome
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Maryland	a s al		19a. Informant's Name/Relationship (Type. Print)	1	= -	and Number or Ru		-		
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סב	8 5 = 5		Burial 2 Ucremation 3 Hemoval from State 1		sition (Name of natory or other plac	i i	Date		cation - City or	·
Baltimore,	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) Me. 21. Signature of Funeral Service Licenses	adowri 22	dge Cem	ss_of_Facility	. 22 , 2007	El	.kridge	e, Marylan
ñ	Dep Imp any		A aluda an Boath	8	VANS FUI 800 Har:	ford RO	AD PAR	& CR KVII	LEMATIC LE, MA	ON SERVICE ARyland 21234
	*		23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.							Approximate Interval Between
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	/Medical Examiner		Due to (r al a conse	quence of):						
		Je.	Sequentially list conditions, if any, leading to immediate Due to (or 15 a c gise	equence of):			_			
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68760,	ficate be executed physician and s the burial-transit	edical	d			_				
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	0 0 0	Physician/Me	in the past 12 months? 1 Yes 2 No 1 Yes 2 No		Ectopic pregnancy Other (specify)	<i>y</i>			Month	Day Year
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VItal		Be C	25. Was case referred to medical examiner?			26. Place of Dea			1 1 1 1 1 1 2	2 110
<u>-</u>	Physician: this certific	To	1 Yes 2 No Hospital: 1 Inpatient 2	BR/Outpatien		4 🔼 Nursing H			6 □Other (Spe	cify)
	ding Phys 1. After this funeral di	ion	27. Manner of Death 1 Natural 1 Accident investigation 1 Accident investigation	28b. Time of Injury	Wor	yat k? Yes 2 ∐ No	28d. Describe	how injur	y occurred	
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined building, etc. (Spec	home, farm, str cify)		.00 2	28f. Location (ural Route Number,
ם	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	OI	One Contifies 4 Contificing Physicings To the heat of my late	a surla da a da atl	a consumed at the sti					
	e Hos 24 ho e Fun etely i	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examine and manner stated.							
	To the within To the compl	Me	29b. Signature and this of certifier		29c. Licens	e number		29d. Dat	te signed (Mont	h, Day, Year)
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	5		Sebasticn K 704 308	m 23a) (Type,	Print) Hern A	renne	But.	rere	e Mo	21224
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature	20 c					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 Z335 M Physician 2007 eodore /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore VAMC 10 N. Green Street Baltimore, MD If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day. **Funeral** 1**X** M 2□F 04/02/1932 75 Director 218-28-6299 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A MD BALTIMORE 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be r 4505 W. FOREST PARK AVENUE 21207 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No KOREA If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. TE filed within 72 hours after 1 X Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN INSTALLMENT .. Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDLAVITCH SHARGEL REBECCA 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains 7 SLADE AVENUE APT. #221 - BALTIMORE, MD 21208 DEBORAH BLANK / DAUGHTER 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition MARYLAND VETERANS GARRISON FOREST 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/18/2007 OWINGS MILLS, MD. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Matt 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pulmonary
Due to (or as a consequence of): Physician hypertension disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending physic for use as the b 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed /es 2 🛂 1□ Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) မ 09/12/2007 NPI:1871701631 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. Baltimore, MD 21201 George 10 N. Green 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

nan raur Sing		1- For State Registrar		cate of De			g. No. 200	7 3004
Physici Medical Exami	an/	Decedent's Name (First, Middle,Last)				2. Date of Death Month September	n	3. Time of Death 1133 hrs
ileuicai Exami	IICI	BRIAN PAUL 4a. Facility Name (if not institution, give street and number)	SMI	TH 4b. Cit	y, Town, or Location		4c. County of Death	
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any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
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ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 714 BARTLETTE AVENUE		10f.	Zip Code 21218	. 10	og. Citizen of What Cou USA	ntry?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Menal Hygens Ham "matural", or items 23a or 28a-f she uni. If item 27 is marked ofter than "natural", or items 23a or 28a-f she uni. If item 27 is marked ofter than "natural", or items us a concept of the west of the world is a fonce or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2	Ever in U.S.		edent of Hispanic Ori ecify Cuban, Mexican	gin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
hours after 'natural'', C Examiner	by	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade com			2 X No specify.		Specify: BL2	ACK
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21215-0036 uld be filed within 7. Mental Hygiene. marked other than c event, the Medical	Be Co	17. Father's Name (First, Middle, Last) DAVID JOHNSON				r's Name (First, Middle, M DÚIVINIA S		
212 ould be I Menu mark ic even	To B	19a. Informant's Name/Relationship (Type, Print)	1	9b. Mailing Addr		mber or Rural Route Num		e, Zip Code)
MD nd 2 sho ulth and m 27 is aumati		LOUIVINIA SMITH (mothe:				AVE. BALT		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Sta		e of Disposition (atory or other pla	Name of cemetery, ice)	Date SEPT.21,2	20c. Location - City or	Town, State
Itim it. Pag	Н	4 Donation 5 Other Specify: 2 Signature of Funeral Service Licensee	TRIN	IITY CF	METERY and Address of Facilit	ľ	BALTIMOF	PF,MD.
Depa Derm		Marianal Star	Upm	CAL	VIN B. S	CRUGGS FU	NERAL HOM Balto, Md	ME 21213
Physician		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the onth o	not enter the mo		cardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
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. D. ≖ .≝	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a conse	quence of):					
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687 certifica ding p	/sician/I	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea	ath 3 Ectopi	c pregnancy .		Day Year
Box 687 he death certific the attending p	ysic	1 Yes 2 No 9 Unknown g Unknown	time of death	5 Other (\$	Specify)			
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Records, The law require	Completed					24a. Was a autop: perfor	sy prior to	utopsy findings available completion of cause of
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t of ling Phy After th	n: To	27. Manner of Death 28a. Date of Inju	ry 28b	. Time of Injury	28c. Injury at Worl	k? 28d. Describe h	now injury occurred	
ivision or Attendi after death. Director:	atio	2 Accident Investigation		08 hrs	1 Yes 2 🗸	No		
Division of Vital tal or Attending Physician: 15 after death. al Director: After this certicled in by the funeral director.	Certification:	Suicide Could not be		farm, street, fact	ory, office building, e	etc. 28f. Location (S or Town, S 2300 Fast Oliv	Street and Number or Ri tate) ver Street, Baltimore	ural Route Number, City City Md
Division of Vital Records, P.O. Box 687 in the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. The Tuneral Director: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.		29a. Certifier (Check only 1 Certifying Physician: To the best of my	/ knowledge, d			ace, and due to the caus	e(s) and manner as sta	ted.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated.	nination and/or	r investigation, in				
	Σ	29b. Signature and title of certifier	W.D.		29c. License number O.C.M.E.		29d. Date signed (Mo September 16, 2	
		30. Name and address of person who completed cause of di			O.O.IVI.E.		September 10, 2	
3		Donna M. Vincenti, MD Assistant Medic			n Street, Baltim	ore, MD 21201		
	ate	31. Date filed (Month, Day, Year) 2007 (32. Registrar	's Signature	boule				
Regis	ueir	Carrier of the Carrier	-					

State Registrar

31. Date filed (Month, Day, Year) SEP 1 9 2007

6565N. Charles St-Sulte 204 Kendall R Faulknermo 32. Registrar's Signature

Funeral

Director

28a-f show sa or 28a-f show t be notified at ns 23a o "natural" event, the Medical marked other than Department of Important: If it any Injury or c once.

altimore, Maryland 21215-0036

JACQUELIN

Physician /Medical Examiner

use as the burial-Box 68760. for signed by the a P.O. Records, page 2 s certificate Division or Vital director. uneral

within 24 hours a State Registrar

State of Maryland / Department of Health and Mental Hygiene 30046 Reg. No 2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Threat Jacqueline Α. 03:05 AM 17 SEPTEMBER 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SINAL HUSPITAL OF BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 217-86-3709 1-25-1965 Md. Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 X Yes 2 □ No Director Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21213 1613 Darley Avenue Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12th grade Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wendelle Mitchell Threat Alvin ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendelle Threat Mother 1613 Darley Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cem. 9-22-07 Anne Arundel Co., Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East ladip 1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Multinfaret Immediate Cause (Final (erebro Vascular disease or condition resulting in death) Due to (or as a consequence of): 13 days (Septic embol Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Ischemic Spleen and resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by abuse Intravenous 1 🗌 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an autopsy perforn 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To 27 Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Bharat Rattan PAS# 19507 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITAL OF BALTIMORE BHARAT RATTAN MBBS (Resident) 2401 W BEDVEDERE AVE, BALTIMORE 21215 31. Date filed (Month, Day, Year) 32. Registrar's Signature

20, 2007 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** INTER ABBOMINIAL HEMORILHAGE /Medical Due to (or as a consequence of): Examiner POTTIC ABDOMINAL ANEURYSM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner HYPERTENSION and burial-tra Due to (or as a consequence of): ি Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes CHIO; NIC BESTRUCTIVE PULMENARY DISEASE Completed 24a. Was an autopsy performed To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifications. 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 res 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier D-53298 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVENUE BALTIMORE Drew Fuller 4940 31. Date filed (Month, Day, Year) egistrar's Signature State 9 2007 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Vear Month TOPA Barbara M. CPTEMBER 17 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIM RE
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. JOHNS HOPKING BAYNEW MEDICAL ENTER 8. Date of Birth (Month, Day, Year) **January 7, 1918** 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2**X** F 220-07-1363 89 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 1 ☐ Yes 2 No Dundalk Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6721 Bessemer Avenue 21222 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 【No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Beauty Shop 8 years Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Nuedlin George J. Cumberland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1406 Rosewick Avenue, Rosedale, Maryland 21237 Grand Daughter Barbara Dyba 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Of Jesus Cem. Dundalk, MD. ^{22. Name and Address of Facility}
Connelly Funeral Home of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. 21222 Approximate Interval Between Onset and Death HOULS 30 YEARS YEARS 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d, Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth Dete ... Month **Physician** 3:45 am O /Medical 4a. Fecility Name (If institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner turelare Year If Under 24 Hrs. M Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Fore Country) **Funeral** Months Deys Hours 1□M 2ਊF Yrs. Director 578-64-2432 60 Sept 1946 Virginia Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural" ~ " any injury or other traumatic excent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2√2 No Director Anne Arundel Arnold 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2102 USA 305 College Parkway 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ZANo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: black Completed by 3 ☐ Widowed 4 🎇 Divorced Year or Dates: 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 bartender taverns 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Taylor Bertha Marshall ۵ 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) unk Kevin Hairston/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑Other (Specify) in state d Sylva 21. Signature и Funeral Service Ronal d 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street 3222 Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Physiclan/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): attending physician resulting in death) Last Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobecco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Onknown 1 ☐ Yes 2 ☐ No ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed Jas 1 Tyes a No 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 A Residence 6 Other (Specify) ို 1 | Yes 2 INO After this erel Director: After thi filled in by the funeral 27. Manner Deeth Medical Certification: 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

8601

1 Yes 2 No

Veterans Huy Millers ville

1 Prifying Physicien: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year)

Box 68760. Division of Vital Records, P.O.

> State Registrar

1 Latural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of tifier

SEP

21 31. Date filed (Month, Day, Year)

CFP 1 9 2007

5 Pending investigation

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hours e To the Funerel C completely filled

			F	State of Marylan		of Health and	•	me o o =	00010
			1 - For State Registrar	,	Certificate		Reg.	2001	30049
	Physici	an	1. Decedent's Name (First, Middle, La	st)			2. Date of Death	PayYear	3. Time of Death
	/Medi		Cathorine	(0)180			9-13	-07	B:00p ™
	Examir	er	Eacility Name (If not institution, giv	1/	46. City, To	vn, or Location of Deal	n 1	4c. County of Death	h •
	Funeral		5. Social Security Number 6. S				8. Date of Birth	9. Birtl	hplace (State or Foreign untry)
	Director		42-60 7137	OM 2004 75	Yrs. Months D	ays Hours Min	OS, 24	1932 M	aryland
	and bw		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
	Mary 1-f sh	ţō	MD	T	Sa Himor	70 1			1 ØYes 2 ☐ No
	or 284	Sirec	10e. Street and Number	l -	10f. Zip Co	de	10g.	Citizen of What Co	untry?
	hours after death with the Maryland tural', or Items 23a or 28a-f show at Examiner must be notified at	Funeral Director	I Eastern B			124		USA	
(0	r Item	Fun	11. Marital Status ✓ Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No	If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	ncan Indian, e, etc.
903	ral', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 □ Yes 2 🔀	No Specity:		Specify:	Shite
21215-0036	"natu	Completed	15. Decedent's Er (Specify only highest gra	ducation de completed)	16a. Decedent's Usual O (Give kind of work of	one during most of wa	rking 16b	. Kind of Business/l	Industry
12	e filed within al Hygiene. cother than "	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Storo .	Peric		Krea	e.5
nd	be filed tal Hygid d other svent, II	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, Maid	len Sumame)	
yla	should be nd Mental marked o	Q.	James Philip	Wilson		Cath		foller	•
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic svent, the Madical Examiner must be notified at		19a. Informant's Name/Relationshid (Type, Print)	19b. Mailing Address (Si	reet and Number or R	ural Route Number, Cit	y or Town, State, Z	(ip Code)
	s 1 an f Heal ftem 2 other		20a. Method of Disposition	20b. P	ace of Disposition (Name of	ronge	Date 20c.	Location - City or 1	Town, State
Baltimore	Pages nent of int: If It iry or o		1 ☐ Burial 2 ☐ remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemoval from State	emetery, crematory or other	OMA ON 4 9	/17/07.B	Himo	O.M.
3alti	permit. Page Department i Important: If any injury or once.		21. Signature of Funeral Service Licer	see	22. Name and A	ddress of Facily	treveral.	Servia	\ <u>\</u>
ш	205 2		John March	7 WBOd7	14 3000	E. Balto	St. Bal	Servia 26.MD	
П			23a. Part 1. Enter the disease, docom shock, or heart failure. List only Immediate Cause (Final	11 1 - 0		^	c or respiratory arrest,	15	Approximate Interval Between Onset and Death
}	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	rterioselecto	e Corna	, Unicalas	lizeuri	Loave
H	Examiner		Sequentially lies conditions	b	0.100 01).				
, L	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):				
6x	xecut	хап	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):			_	
8760,	icate be executed physician and s the burial-transit	ical		d					
99	ng physical	Medi	IF FEMALE:						
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar	death 3 Ectopic pregn			23d. Date of deliver Month	very Day Year
P. O.	by the a	Physician/Med	1 Yes 2 No	4□Pregnant at time of de 9□ Unknown	ath 5 ☐ Other (specif	()		NOTE:	Day roar
σ.	Attending Physicien: The law requires that the death certific redeath. After this certificate has been signed by the attending p ector. After this certificate has been signed by the funeral director, page 2 should be detached for use as the funeral director.	by Ph	Part II. Other significant conditions of	ontributing to death but not resu	Iting in the underlying cause	given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Records,	w require been sig should b	ed b	Heripherel V Ascolaci	Duase			1 ☐ Yes	2 □No 3 □ Pro	obably 4 Unknown
ecc	e law re has be je 2 sho	Completed	Choosic Kidney	decare			24a. Was an autopsy	24b. Were aut	topsy findings available ompletion of cause of
a H	ysician: The is certificate his director, page		Sacral develop	רל			performed? 1 ☐ Yes 2 ☐	death?	2□ No
Vita	siciar certif irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			ath Check onl one		
o	ding Phys th. After this funeral di	\vdash	27. Manner of Death		R/Outpatient 3 DOA 28c.	njury at Work?	tome 5 Residence 28d. Describe how in	6 ∐Other (Speci jury occurred	ify)
ion	ttendin death. ctor: Aft / the fun	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation			Work? 1 ☐ Yes 2 ☐ No			
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	spital ours a leral [29a, Certifier 1 Certifying Ph	ysician: To the best of my know	yledge death occurred at th	e time, date and place	and due to the source	(s) and manner as	stated
	To the Hospital or Atten within 24 hours after deal To the Funeral Director: completely filled in by the	edical	(Check only 2 ☐ Medical Examone)	iner: On the basis of examinati and manner stated.	on and/or investigation, in r	ny opinion, death occu	rred at the time, date a	nd place, and due	to the cause(s)
	Your Your Touth	×	29b. Signature and title of certifier		29c. Lio	ense number	29d. [Date signed (Month)	, Day, Year)
	N I		Herewood (re	anomo		9667		-12-500	7
	3		30. Name and address of person who	completed cause of death (Item	O HEALERY# C	08 Glen Ross	ier Haylan	ld 21061	
	Sta	e	31. Date filed (Month, Day, Year)	32 Megistrar's Signati	Tre		, ,		
	Registra		SEP 1 9 2	307 Degues L	F GOODES				

			For State Registrar	State of Maryla	•	artment of F		-	rgiene Reg. No 2007	30050
ľ	Physici		Decedent's Name (First, Middle, Last Joey	>t)	Wills			2. Date of De Month	eath Day Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give	<i>'</i>	2R	4b. City, Town, o	or Location of Dec	ath	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. S	ex 7. Age (In y	rs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		rth 9. Bir ay, Year) Co	thplace (State or Foreign buntry) Md.
	Maryland -f show fied at	tor	10a. State 10b. County NA	10c.	City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the 23a or 28a st be noti	Funeral Director	10e. Street and Number 1005 N. Gaystreet	Apt. 301		10f. Zip Code 212 0)5		10g. Citizen of What Co	ountry?
136	thin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show Medical Examiner must be notified at	by Funer	11. Marital Status 1√ Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 May Yes 2 □ No If Yes, Give Year or Dates;		Was Decedent of H f Yes, specify Cub I ☐ Yes 2 ☑ No	Hispanic Origin? Jan, Mexican, Pud Specify:	(Specify Yes or No erto Rican, etc.)		
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Maryie	2 should n and Mer is marke raumatic	P_	19a. Informant's Name/Relationship (19b. Mailir	•	and Number or		Madison per, City or Town, State,	
artimore, n	Pages 1 and 2 sh nent of Health and int: If item 27 is rr iry or other traun		Walter Jefferies 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification of the content of the cont	Removal from State	b. Place of Dispo		ce)	Apt. 301 Date -25-07	, Baltimore 20c. Location - City or Owings Mil	Town, State
Battl	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licer	"	22	. Name and Addre	ess of Facility	March F.		21202
j.	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. CENTRAL Due to (or as a cons	eath. Do not ent	er the mode of dyi	ng, such as card	iac or respiratory a	arrest,	Approximate Interval Between Onset and Death
g/pn, //	te be executed ysician and le burial-transit	dical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a cons						
O. Box 62	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	Ectopic pregnanc	у		23d. Date of de Month	slivery Day Year
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al Records	g 8 0	Completed						24a. Was auto perfo 1∐ Yes	s an 24b. Were a prior to death?	utopsy findings available completion of cause of
DIVISION OF VITAL	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 16 27. Manner of Death 1 Matural 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year		28c. Inju Wor M 1	ner: 4 Nursing	28d. Describe	idence 6 □Other (Spe how injury occurred	
	pital or Aturs after deral Direct		4 ☐ Homicide determined	building, etc. (Spe				City or To		
	the Hos thin 24 ho the Fun	Medical	(Check only 2 Medical Exam	niner: On the best of my land manner stated.	nination and/or in	vestigation, in my	opinion, death oc	ccurred at the time	cause(s) and manner a , date and place, and du 29d. Date signed (Mon.	e to the cause(s)
	F » F ŏ	_	30. Name and address of person who are the state of the s	MEDICAL A77 PH-9	SICIAN (Type			39		
	Sta	te	31. Date filed (Month, Day, Year)	to St. Registrar's Si	gnature	6 4702	To	were, M	16 31804.	
	Registr		SEP 1 9 2	107 Dogues	& So	3000				

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of l artificate of			giene 0	07	30	051
	Physic	an	1. Decedent's Name (First, Middle,	Last)				2. Date of Dea	ath Day	Year	3. Tir	ne of Death
	/Medi		BENJAMIN			WELBO		SEPTEMA		2007	. 03	:22 AM
	Exami	ner	4a. Facility Name (If not institution,			4b. City, Town,	or Location of Deat	h	4c. Count			
				Sex 7. A	Solfa Jast birthday) If Under 1 Year	1 More (8. Date of Birtl		NA	-1 (0	
н	Funeral Director			1 ★M 2 ☐ F	67 Yrs.	Months Days		(Month, Day	,, _{Year)} -1940	9. Birth	intry)	tate or Foreign
	ס		212–36–0196 Usuel Residence of Decedent					0027	-1940		Mo	a
	anylan show	_	10a. State 10b. County		10c. City, Town or L	ocation						de City Limits
	8a-f.	Director	Md. NA		Baltim	ore					X	Yes 2 □ No
	with the		10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?	
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	hours after death with the Maryland turel; or Items 23a or 28a-f show at Exartiliser must be notified at	Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie	12. Was Decedent Armed Forces	?	Was Decedent of I If Yes, specify Cub	hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)		ce - Ameri ick, White,		in,
036	urs a	þ	3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specif	y: B]	lack	
5-0036	n 72 hours after death with the Marylan "naturel", or Items 23a or 28a-f show odfical Exantiner must be notified at	Completed	15. Decedent's (Specify only highest	Education		edent's Usual Occup a kind of work done		rking	16b. Kind of B	lusiness/Ir	dustry	
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	Hygier Hygier Ither th		pth grade	NA		Disabled			NA			
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, Ine M	Be	17. Father's Name (First, Middle, La Benjamin	ist)	Malla anam			me (First, Middle,				
Ž	hould d Men marke matic	ို	19a. Informant's Name/Relationship	(Tuno Print)	Welborn	ing Address (Street		othy		Culle		
Ma	and 2 sealth an n 27 is.	10	George E. Parris			Boone St					(Code)	
ē,	Heg Heg the		20a. Method of Disposition	1, 01. 50	20b. Place of Disp	osition (Name of	1	Date Date	20c. Location		own, Sta	te
Ê	m O		1 ☑ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe			matory or other pla	1				_	
Baltimore,	그 돈 뿐 글		21. Signature of Funeral Service Lie			mel Cem. 2. Name and Addre	ess of Facility	1-07 March F.	Dundal H. Eas	-	4.	
8	Depar Impo any ir	. 1	& lady	Wane		1101 E.	North Ave	e., Balti	imore,	Md.	2120)2
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause ily one cause on each li	d the death. Do not en	ter the mode of dyir	ng, such as cardiad	or respiratory arr	est,		Approx	rimate I Between
	Physician		Immediate Cause (Final disease or condition	LEN	EMRAL E	DEMA					Onset	ove S
	/Medical Examiner		resulting in death)		a consequence of):							
	Zammer	_	Sequentially list conditions, if any, leading to immediate	b. ME	TASTATZC a consequence of):	CANC	ER				2 7	YEARS
10	ted nsit	Examiner	Cause. Enter Underlying Cause (Disease or injury				150				7	VEALC
,	n and ial-tra	Exai	that initiated events resulting in death) Last	cDue to (or as	a consequence of):	LUTN						IL MICS
68760,	ficate be executed physician and is the burial-transit	edical		d								
w	ntifical ng phi as th	ledi	IF FEWARE									
Вох	death certifica attending ph I for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth		Ectopic pregnancy	v			te of delive	•	
	at the dea by the at tached fo	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at 9☐Unknown		Other (specify)			Mo	onth	Day	Year
P.0	that the		Part II. Other significant conditions	t contributing to death b	ut ant constitue in the		and Deat	OSo Dida		الا مد مدساند		a fala a th O
Records,	The law requires that the death certif tte has been signed by the attending page 2 should be detached for use a	1 by	Facili. Other significant conditions	contributing to death b	at not resulting in the t	inderlying cause giv	en in Pan i.		bacco use coni es 2□No			unknown
Ö	w requ	Completed										
Re	The lavate has	m						24a. Was a autops perfori	sy 📗			ngs available of cause of
Vital			25. Was case referred 6 medical					1 ☐ Yes	2 PNo	1 🗆 Yes	2 No	
>	Physicien: this certific al director,	o Be	examiner?	Hospital: 1 Inpatie	ent 2 ☐ ER/Outpatie	nt 3□ DOA Oth	er	th (Check only on ome 5 - Reside		or /Consid		
J of		n: T	27. Manuar of Death	28a. Date of Inju (Month, Da	ry 28b. Time o			28d. Describe ho			"	
Ö	Attending I r death. ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	ion	y Year) Injury		Yes 2 □No					
Division		Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (St City or Town	treet and Numb n, State)	er or Rura	l Route	Number,
Ω	oitel or urs afte rel Dir Hed in											
	e Hospitel 24 hours a e Funerel D etely filled i	Medical	29a. Certifier 1 Certifying 1 (Check only one)	Physician: To the best aminer: On the basis of	fexamination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and ma ate and place,	anner as s and due to	tated. the cau	ise(s)
	To the Hos within 24 ho To the Func completely f	Mec	29b. Signature and title of certifier	and manner sta		29c. Licens			9d. Date signe			
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	0	1	00 None and address of Assessite		OCTOR eath (Item 23a) (Type.	-	-000		EPTEMI			2007
	7		SOLE VARUAS THE	Source Hopical LINE T 74	L GO IMATI	ILMITE C	TREET RAI	77 M - A C	AA AA V	. 4	21102	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	AP A	WILL 2	11 1111	- COOKE	/*/TF/	-HW.12	1001
	Registr	ar	214 1 4 70	11 March 18 0	() LANGA	V 2 18						

07-07197 Calvin Walker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death	Reg. No. 2007 3005
Physicia Medical Exami		r Calvin Walker	Date of Death Month Day Year September 16, 2007 3. Time of Death 0720 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2608 Pierpoint Street Baltimore	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 14-58-661 1X M 2 F 7. Age (In yrs. last birthday) Yrs. Months Days Hours Min. Usual Residence of Decedent	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
land f show any	tor	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 XYes 2 No
eath with the Maryland items 23a or 28a-f show ist be notified at once.	I Director		10g. Citizen of What Country?
after death wit al", or items 2 ner must be n	by Funeral	3 Widowed 4 Diverged If yes Give Yes	ify Yes or No- can, etc.) 14. Race - American Indian, Black, White, etc. Specify: Back
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mehral Hygene. Instit: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Completed t		
MD 21215-0036 82 should be filed within 7 th and Meina Hygiene. a 27 is marked other than cumatic event, the Medica	Be	Kaleigh H. Walker Nan	irst, Middle, Maiden Surname) Vie A. Wade
ore, MD 2 s 1 and 2 shoul of Health and M of Item 27 is m	입	Nannie A. Walker (Mother) 1603 Roundview Rd. 7	al Route Number, City or Town, State, Zip Code) 21225 Valte 20c. Location - City or Town, State
Battimore, MD 21215-00; permit Pages I and 2 should be filed with Department of Feathh and Metral Fygiene Important: If item 27 is marked other timportant: or other traumatic event, the Metrope of the property of other traumatic event, the Metrope of the page of the pag		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	glo7 Brooklyn, MD
Balt Bermit Departi Import		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re	ne funeral Services 4 Ko Batto. MD 21729 espiratory arrest, shock, or heart Approximate Interval
/Medical caminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic dru use Due to (or as a consequence of):	Between Onset and Death
ed .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):	
60, te be executed ysician and burial - transit	/Medical		
an	Physician/Me	izop, was decedent prednant in the	23d. Date of delivery Month Day Year
ires that the displayed by the	출		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. ral or Attending Physician: The law requires that th rs after death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed		24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
Vital Reysician: The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital: 4 Institute Company Content of the c	y one)
n of Viding Physion. After this funeral dir	의: L	27 Manuary of Death	d. Describe how injury occurred
Division Hospital or Attent 24 hours after death Funeral Director:	Certification:	A Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28 (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hosp within 24 hos To the Fune completely fi	edical		1.7
	Ž	29b. Signature and title of certifier 29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) September 16, 2007
Ball		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta Registr		A 100 M A A A A A A A A A A A A A A A A A A	
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nysicia		1. Decedent's Name (First, Midd GRACE E. WALTE	. ,						2. Date of De Month	Day	^{Year} 2007	3. Time of Deat 1:00P
Medic xamin	-	4a. Facility Name (If not institution		number)		4b. City, To	own, or Locati	on of Deat	th	4c. C	ounty of Death	
***		GENESIS ELDER					KLYN P				E ARUNI	
neral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs.	iast birthday) 89 ^{Yrs.}	Months (Days Hou	der 24 Hrs rs Min.		ıy, Year)	Cou	place (State or For ntry)
ector		214-24-0118 Usual Residence of Decedent			09				7-20-15	10	MD	
3		10a. State 10b. Count	у	10c. Ci	ty, Town or Lo	ocation						10d. Inside City Lin
allies	Director		ARUNDEL	BRO	OKLYN I							1 ☐ Yes 2 🔯
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any injury or other traumatic e		19a. Informant's Name/Relation	iship (Type, Print)		19b. Maili	ing Address (Street and Nu	ımber or R	ural Route Numb	er, City or	Town, State, Zi	p Code)
her tr	١.	MR. LESLIE W.	WALTER/ S	SON	245 E			E BRO	OKLYN PA		U 21225 ation - City or T	
or ot		20a. Method of Disposition 1 ☐ Burial 2 X Cremation			cemetery, cre				EMBER 18		ENSVILL	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 14, 2007 **Physician** 2:30P M ANNE LORRAINE WIENECKE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore County MANOR CARE - DULANEY Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Apr 21,1920 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 🗑 F 87 Yrs. 215-09-2750 Maryland Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or Items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore County Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3715 Middle River Avenue 21220 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner | Stationary 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Delsie Gordon Harry Benson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Regester Avenue, Baltimore, Maryland 21212 Wayne Paul Wienecke (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/18/2007 Moreland Mem Park Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signal for Fun Service Library

Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Renal Disease /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of. Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown certificete has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown Be Completed Lung Cancer 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rmear 2∰ No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z-No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury s after decret ral Director: Alter 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a the Hospital 29a. Certifier 📤 Centifying Physician: To the best of my knowledge, death conumed at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number H0054970 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Katherine Asadi, M.D., 20 E. Timonium, MD 21093 Suite 209 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 9 2007 Registrar

To the

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KAUAN.

AMENT, PARRICIA

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

29c. License number

ES 000

tOSPITAL OF

29d. Date signed (Month, Day, Year)

BACT IMORE

07

and manner stated.

gistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

SHARMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 30057 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** August 31, 2007 Agnes Μ. Aristorenas 1:05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 18752 Ginger Court Montgomery Germantown 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 217-86-5997 1 □ M 2 13 F 39 July 15, 1968 Philippines Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Exa⊡lner must be notified at Marvland Montgomery Germantown 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 18752 Ginger Court United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Specify: Filipino ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Paralegal Law Firm 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raul T. Aristorenas Jazmin Lingad ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Raul T. Aristorenas (Father) 18752 Ginger Court, Germantown, MD 20874 20b. Place of Disposition (Name of crematory crematory or other place) 20a. Method of Disposition September 20c. Location - City or Town, State cemetery, crematory or o Metropolitan 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 5, 2007 Alexandria, Virginia Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.

Immediate cause Final disease or condition

Metastatic Breast Cancer Approximate Interval Between Qnset and Death years **Physician** resulting in death) /Medical Due to (or es e consequence of): Examiner Right Breast Cancer 6 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the bunal-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) filled in by the funeral director, page 2 should be detached the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1□ Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) ို 1 ☐ Yes 2 ☒ No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending 1 X Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 31, 2007 D37236 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carolyn B. Hendricks, M.D., 6410 Rockledge Drive, #506, Bethesda, MD 20817-1899 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 5 2007 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 30058 Reg. No UU7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 09 08 07 Robert Barnstricker 1156 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS- Braddock CAmpus Cumber land Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 21, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Days Hours Μ̈́D 1934 214-28-7143 Director 73 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Cumberland MD Allegany Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 829 Virginia Avenue permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23 any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑☐ Yes 2☐ No If Yes, Give Year or Dates: 1951-53 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 📈 No Specify: Specify: ۾ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Celanese Corp 12 iaborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George W. Barnstricker Gloria Barnstricker 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21666 208 Oregon Road Stevensville cousin Linda Anderson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐XCremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 9/14/2007 MD Cresaptown 4 ☐ Donation _5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enfock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final **Physician** Atherosclerotic Heart Disease resulting in death) /Medical Due to (or as a consequence of): Examiner Metastatic Testicular CAncer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Depression 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔯 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 □ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier (Check only one) 1 detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. To the l within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD. 00066101 Haven 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Seton DR. Cumberland MD 21502 CHEEMA MANAN APROOL

Registrar

State

31. Date filed (Month, Day, Year)

1 9 2007

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** CLARA BURNS SEPTEMBER 2007 /Medical 1, 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MANOR CARE NURSING HOME POTOMAC MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days | Hours | Min. | 11/27/1920 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖺 F 86 184-05-9571 Director PΑ Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a State 10h County 10c City Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director NEVADA LAS VEGAS CLARK 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9700 BLUE BELL DRIVE 89123 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE ģ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CO-OWNER FURRIER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HYMAN ROSENTHAL ပ DORA GOODMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARYN GOLDMAN/DAUGHTER 8513 GAVIN MANOR COURT, CHEVY CHASE, MARYLAND 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NATIONAL CREMATORIUM 09/07/2007 FALLS CHURCH, VIRGINIA 21. Signature of Funeral Service Licensee 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, storing one cause on each line. 23a. Part1. Ther if the shock, or heart failur Approximate Interval Between Onset and Death immediate Cause (Final **Physician** Lung Cancer with Metastases to Brain disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached i 9 Unknown 9 Unknown signed to Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🏄 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s 2**K** No 1☐ Yes To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier l 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20274 September 4, 2007 /δ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bethesda, MD 20817 Kirti Vohra, MD 7710 Bradley Boulevard 31. Date filed (Mont Stap Year) 5 gistrar's Signature State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 30 2007 7:40 August Bonney Evelvn Esther /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 😡 F 1918 88 Sept 11, Maryland Director 220-03-4014 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Frederick Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. United States 8206 Greenvale Drive 21702 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Edna L. Gall Edward A. Nicholson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) f Health a Patricia B. Shank / Daughter Frederick, Maryland 21702 8206 Greenvale Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot September 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5, 2007 Blue Ridge Cemetery Thurmont, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Sign were of Fun ral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Lisease or nijury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pi 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes No 5 ☐ Other (specify) signed by the a I be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 24a. Was an certificate has b irector, page 2 sl autopsy 1☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 npatient 2 ER/Outpatient 3 DOA 1 Tes Medical Certification: To this 28d. Describe how injury occurred 27. Manner of Leath 28a Date of Injury 28b. Time of 28c. Injury at Work? After Natural 5 Pending investigation within 24 hours are control to the Funeral Director: Af 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 🕇 CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

Robert L. Kaufmann 31. Date filed (Month, Day, Year) State 2007 SEP 05 Registrar

30. Name and address of person who complete

29b. Signature and title of certifie

(Check only one)

300 W. Ninth Street Frederick, Maryland 21701 M.D

cayse of death (Item 23a) (Type, Print)

and manner stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 31, A^{M} 7:00 2007 MADELINE AUGUSTA BISHOP August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 131 Cody Drive Unit 11 Thurmont Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 2 🙀 F Oct. 20, 1927 Maryland 217-28-1599 79 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural", or items 23a or 28a-f show 10d, Inside City Limits 10c. City. Town or Location 10b. County r 28a-f show notified at Yes 2□No Director Maryland Frederick Thurmont 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a or 2 must be n 21788 131 Cody Drive Unit 11 U.S.A. Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. "natural", or iten idical Examiner 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3altimore, Maryland 21215-0036 Specify: ð 3 ☐ Widowed 4 ☐ Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Be Gertrude Clay Harry Ezra Etzler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau 131 Cody Drive Unit 11, Thurmont, Maryland 21788 Eugene Bishop / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 9/4/07 Central Cemetery New Market, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Eacility & SON FUNERAL HOMES, P.A. 21. Si priure of Funer II S, rvice Licensee wit 615 EAST MAIN ST., THURMONT, MD 21788 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a Part 1. Enter the disease Cardinarala Vireare Immediate Cause (Final disease or condition resulting in death) Sulven therosclerit Physician /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed burial-transi and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical e esn IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9 Unknown 9 DUnknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Inpatient Certification: To this 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 27. Manner of Death After (Month, Day Year) Injury 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined filled in by 4 ☐ Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completely f (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D31058 8/31/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Gene (F. Ashe, MD Woodsboro Medical Center, Woodsboro, Maryland 21798 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene 30062 Reg. No 2 0 0 7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 11, 2007 9:20 A.M Mary M. Caffery /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Solomons Solomons Nursing Center 8. Date of Birth (Month, Day, Year) 04-21-1917 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2√2 F PA90 Director 179-12-3234 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 'natural', or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 ▼ No Director Lusby MD Calvert the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with United States 20657 11437 Horseshoe Trail Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. e filed within 72 hours after all Hygiene.

other than "natural", or iter 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore. Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White Specify: 2 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Housewife 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Mental Mary M. Gill n and Menta Michael T. Manahan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11437 Horseshoe Trail, Lusby, Maryland 20657 Gerry E. Caffery (Son) of Health Item 27 i Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages:
Department of IImportant: If Ite
any injury or of 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 9/13/07 | Alexandria, Virginia 21. Signature of Funeral Service Licens 22. Name and Address of Facility Rausch Funeral Home, P.A. St P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FIBRILLATION ATRIAL Physician Leens /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Lines throughing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Cg the burial-tran Due to (or as a consequence of): physician Physician/Medical as t IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₹ VASCULAR DISEASE PERIPHERAL 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has be irector, page 2 s performe 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred funeral 28c. Injury at Work? Certification: After Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 7) 29b. Signature and title of certifier September 11, 2007 Physican Allender 30. Name and address of person who completed cause of beath (Item 23a) (Type, Print)

State Registrar Anwar Munshi, MD

SEP 1 9 2007

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

110 Hospital Road, Suite #303, Prince Frederick, MD 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 30063 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Fern A. Cesky September 2007 8:22 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1519 Dr. Jack Road Conowingo Ceci1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Ser 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 XF Days Hours Min 220-09-9825 90 January 22,1917 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director MD Ceci1 Conowingo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1519 Dr. Jack Road 21918 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3K Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker Department of Health and Mental Hyg Important: If Item 27 is marked other eny Injury or other treumatic event, I and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fill truent of Health and Mental Hitem 27 Is marked others. Willis Rickert Anna B. Hassel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne M. Narvel/Daughter 1519 Dr. Jack Road Conowingo, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 9/13/07 Rising Sun, Maryland R.T.Foard Funeral Home,P.A 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service 111 S. Queen Street R.T. Foard Funeral Home, P.A. Rising Sun, MD 21911 23a Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in feath)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 NO 1 Yes Hospital or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 Yes 2 No 5 Residence 6 □Other (Specify) erel Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours e To the Funerel C completely filled 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29d. Date signed (Month/ Day, Year) 29b. Signature and title of certifier ino

State Registrar

DHMH 17 Rev 1/2001

31. Ďate filed (Month, Day, Year)

lame and address of person who completed cause of death (Item 23a) (Type, Print)

DIMONSON 32. Registrar's Signature

MD III W. Hi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 3:55 p^M 2007 September 2, Frances Conaty Jean /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery 3409 Parker Creek Lane Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days **Funeral** Hours Months 1 □ M 2√ F Sept. 22, Massachusetts 72 Director 011-26-8628 Usual Residence of Decedent 10d Inside City Limits death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be 20906 USA 3409 Parker Creek Lane Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: filed within 72 hours after Specify.White 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No "natural", or þ 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) the Medical Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Administrative Assistant permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important; if item 27 is marked other the any Injury or other traumatic content 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anastasia O'Neil Francis Cavanagh 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11519 Bucknell Drive, Silver Spring, MD 20902 Jean Caffes/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Sept. 7, 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 0 4 ☐ Donation 5 ☐ Other (Specify) 2007 Silver Spring, Maryland 22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd, W., Silver Spring. MD 20901 amo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Respiratory Failure 2 Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 15 Months Metastatic Melanoma Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No ed by the a 9 ☐ Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertension 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perform Yes 2 1 Yes 2 No 1 certificate Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After (Month, Day Year) Injury 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death.

• Funeral Director: A
sletely filled in by the fu

Maryland 21215-0036

Baltimore,

within 2 2

the

Medical

29a, Certifier

29b. Signature and title of certifier

	30. Name and address t										
	Linda M.	Burrell,	M.D	2730	University	Blvd,	W.,	#400,	Wheaton,	MD	20902
State	31. Date filed (Month, P	P - 5 2007	32. 2	gistrar's Sig	gnature M. Acad						

Orever St.

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D35996

29d. Date signed (Month, Day, Year)

September 4, 2007

		for State Registrar	State of Maryl		artment of rtificate of		Mental Hy	giene Reg. No. 2	2007	30065	
Physic	nian	1. Decedent's Name (First, Middle,	Last)				2. Date of De Month	Day	Year	3. Time of Death	
/Med		Jose		tillo			Septem			3:30 A ^M	
Exam	iner	4a. Facility Name (If not institution,				or Location of Deatl	h		ounty of Death		
		1100 Highwood F		yrs. last birthday	Rockv		8. Date of Bir		ontgome	ry lace (State or Foreign	
Funera Directo		,	157 M 2 T E	yrs. last birtingay, Yrs.	Months Days		(Month, Da	y, Year)	Coun	alvador	
		217-19-3664 Usual Residence of Decedent			J		April .	20,17-	72 HI DO	aivadoi	
nylan how Lat		10a. State 10b. County	100.	. City, Town or L	ocation				1	0d. Inside City Limits	
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vith th	Director	10e. Street and Number			10f. Zip Code				n of What Coun	•	
s 23s	Funeral	1100 Highwood Ro	oad 12. Was Decedent Ever i	in II C 40	2085		Inneify Vac or No		Salvado: Race - Americ		
ter de item	Ę	11. Marital Status 1 □ Never Married 2 ☑ Marrie	Armed Forces?	13.	If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer		.	Black, White,		
urs al	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 X Yes 2 ☐ No		rican	Si	pecify: Salv	vadoran	
72 ho	Completed	15. Decedent' (Specify only highest		16a. Dece	edent's Usual Occu	pation		16b. Kind	of Business/Inc		
iffhin lie.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)			e during most of wor ed)	Ming				
be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		U		Gene	ral Repa	Υ .	ne (First, Middle,		e Mainte	enance	
be fill Personal Pers	Be	17. Father's Name (First, Middle, L				18. Mother's Nar					
hould d Mel marke	မ	Sebast 1 19a. Informant's Name/Relationsh		10h Mail	ing Address (Stree	et and Number or Ru	Fedil:		Castillo		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any once.		Ana Isabel Cruz/		1	-	Road, Ro		· -			
then 27 other to		20a. Method of Disposition		b. Place of Disp	osition (Name of ematory or other pl	1	Date		tion - City or To		
Pages nent of I	U	1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			Mem. Pai	i	/2007	Rocky	ille, M	arvland	
permit. Departm Departm Importal		21. Signature of Funeral Service L			22. Name and Add		eVol Fun			aryrand	
		Civitis E	Lay	10	O East De	eer Park 1	Dr., Gai	thers	burg, M	D. 20877	
Physician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that caused the conly one cause on each line. Metastati			ring, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death 4 MONTHS	
/Medica Examine	-	resulting in death)	Due to (or as a con	sequence of):							
	Je L	Sequentially list conditions, if any, leading to immediate Cause Chief Underlying Cause (Disease or injury that initiated events	Due to (or as a con								
be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events country in a consequence of the country in the co									
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atter i for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	□Ectopic pregnan □ Other (specify)	су		201	Month	Day Year	
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en sig	ed k				<u> </u>		1 🗆	Yes 21	No 3 ☐ Prob	ably 4 □Unknown	
law ra as be 2 sho	Completed						24a. Was		24b. Were auto	psy findings available npletion of cause of	
The ate h	lo.						perfo 1∐ Yes	rmed? 2 X No	death? 1 ☐ Yes		
clan: ertific ctor,	Be (25. Was case referred to medical examiner?					ath (Check only o	one)			
hysi this c	은	1 Yes 2 No		2 ER/Outpatie	IN SUI DOA		lome 5 K Resi			y)	
ding Phystcian: The lav n. After this certificate has funeral director, page 2 v.	io io	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	l W	uryat ork? ⊒Yes 2 ⊒No	28d. Describe	how injury o	occurred		
death ctor:	icat	2 Accident investig	ot be 380 Place of injuny	At home, farm, si			28f. Location /	Street and I	Number or Bura	l Route Number	
tal or Arsafter al Dire	Certification:	3 ☐ Suicide 4 ☐ Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rura City or Town, State)									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		g Physician: To the best of my Examiner: On the basis of examiner stated.								
29b. Signature and title of certifier 29c. License number								29d. Date signed (Month, Day, Year)			
10		Mulor	myremo		D233	308		Septe	mber 4,	2007	
		30. Name and address of person v		(Item 23a) (Type	Print)	o C	/.100 P-	+h	a MD a	0817	
		Dr. Victor M. P			_	r. Suite#	+100 Re	Luesa	a, FID 2	0017	
S Regis	tate	31. Date filed (Morth Park)	2007 32. Egistrar's S	K A	melle						

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 11, 2007 6:30 AMM **Physician** Christine Annette DeWitt /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Frederick 9512 Bridgewater Court, 8. Date of Birth Sept. 27, 1962 Birthplace (State Sept. 27, 1962 Maryland Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 □ M 2 1 F 44 Months Days Hours Min. 216-92-8672 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Maryland Frederick Frederick 1 ☐ Yes 24 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 9512 Bridgewater Court East 21701 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White Completed by 3 Widowed 4 Divorced 'natural" Year or Dates er than "natur, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vice-President/Operations Credit Union d other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file frment of Health and Mental H-fant; If item 27 Is marked oth jury or other traumatic event Be Patricia Thir John A. Barr, Sr. ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. DeWitt, husband 9512 Bridgewater Court East, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery Sept. 15, 2007 Frederick, MD 20a. Method of Disposition Important; If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Fun ral Service License ^{22. Name and Address of Facility} Reeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 MO0255 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one of Immediate Cause (Final 8 Days **Physician** Hepatic Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 3 Years Metastatic Breast Cancer Sequentially list conditions, it any learning to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence off Examiner physician and the burial-trans Due to (or as a consequence of) physiciar Physician/Medical use as t IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Year Day 5 ☐ Other (specify) P.O. the detached 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2XXXVo autopsy performe page certificate 1 Yes 2 XX Physician: funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home XX Residence 6 Other (Specify) 1 ☐ Yes XXNo P 2 ER/Outpatient 3 DOA After this 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending (Month, Day Year) Injury 1XXNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; 2 Accident the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 ☐ Homicide filled Hospital 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053132 September 13, 2007 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 0/ Leisha Ann Emens, Assistant Professor of Oncology, 401 North Broadway, Baltimore, MD 21231 31. Date filed (Month, Day, Year) SEP 1 9 2007 Registrar's Signature Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1230 AM Day **Physician** 2007 1)avis rank /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 40 land View Unive Annapolis If Under 1 Year | Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1**X** M 2 □ F Months Days Hours Min. 578-54-6385 Director 63 21, 1943 Washington, DC Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits show 28a-f sh notified 1 ☐ Yes 2 ☐ No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event. 149 Island View Drive 21401 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify:White Specify Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Steam Fitter Mechanical Contracting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Frank P. Davis ၉ Elizabeth Boyle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Davis, Jr./Son 149 Island View Drive, Annapolis, MD 21401 f Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Hom 500 University Blvd, W, Silver Suns MD 20901 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Concer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: for use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No certificate has been si rector, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2/11 No 1∐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 2000 1 ☐ Yes 1 Inpatient P 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) Jo the Hospital or Attending Pl Jwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of ¢ertifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 32. egistrar's Signa SEP 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900

egistrar's Signature

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Suite 300 Annaly MD

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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 30069 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 4, **Physician** EZIZI7 Janine Ereshevich 11:52PM Ginette /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Center Baltimore Towson 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 □ M 2 🖸 F 80 1927 082-32-8751 France Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location works 10b. County r 28a-f show notified at 1⊠Yes 2 No Maryland Harford Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 'natural", or items 23a or dical Examiner must be 609 Rowe Drive 21001 U.S.A. death v Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical 721 (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. College (1-4or 5+) Four Years Elementary/Secondary (0-12) Homemaker Personal Residence Health and Mental Hygie em 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown unknown ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 609 Rowe Drive, Aberdeen, Maryland Dr. Michael Ereshevich permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 09/07/07 Havre de Grace, Maryland Mt. Erin Cemetery 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A.
Perryville, Maryland 21903-0766 21. Signature of Funeral Service Licensee W. Madelle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ANOXIC ENCEPHALOPATHY **Physician** /Medical Due to (or as a consequence of) **Examiner** CARDIO-RESPIRATORY ARREST if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed ACUTE MYOCARDIAL INFARCTION burial-trar Due to (or as a consequence of) physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown RENAL INSUFFICIENCY cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 XNo 24a. Was an CIRRHOSIS autopsy 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending P 24 hours after death. Funeral Director: After t Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 24 and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) W D31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINTHICUM, 7601 OSLER DRIVE TOWSON, MARYLAND 21204 M. D. RICHARD L.

State Registrar 31. Date filed (Month, Day, Year) SEP 0 6 2

DHMH 17 Rev 1/2001

Baltimore,

Box 68760.

P.0.

Records.

Division or Vital

2. Registrar's Signature

			1- State of Ragistrar	Maryland	/ De	epartment of Hopertificate of I	lealth and N Death	Mental Hygier Reg. 1		30070	
I	Physici	an	1. Decedent's Name (First, Middle, Last)	- OFF	- 1	nan		2. Date of Death	Pay Year	3. Time of Death	
-	/Medic Examin		4a. Facility Name (If not institution, give street and num	nber)		4b. City, Town, or	Location of Death	1	tc. County of Dea	th Total	
			Ellicott City Rehab.	Conva.	Cei	iter	Ellicot	<u> </u>	Howard		
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 1 M 2 1	7. Age (In yrs. Ias 9.7	V-	Months Davs	Hours Min.	8. Date of Birth (Month, Day, Yea Sept. 22	ar) Co	thplace (State or Foreign ountry)	
	D		Usual Residence of Decedent 10a. State 10b. County	10c. City,		r Langtian		sept.22	. 1909 -	10d. Inside City Limits	
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	or 28a	Director	Maryland Howard 10e. Street and Number		-	10f. Zip Code	COLL CI		Citizen of What Co	puntry?	
	ath wil	ralD	3000 North Ridge Ro				21043		S.A.		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other traumatic event, Ite Madical Exaction must be ricilified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 1 □ Yes, Giv. Year or Da	2 🛣 No 9		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify Bla	e, etc.	
2-0	72 hou	eted	15. Decedent's Education (Specify only highest grade completed)		((ecedent's Usual Occup	during most of work	ina 16b.	Kind of Business		
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	illed Hygie other	a l	17. Father's Name (First, Middle, Last)			Teacher	18. Mother's Nam	e (First, Middle, Maid		L	
ylar	Menta Menta arked aric ev	To B	Samue	l Nelso	on		Hatti	e Robins	on		
Maryland	12 shoth and 7 is m		19a. Informant's Name/Relationship (Type, Print)	r		Nailing Address (Street:				21045	
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E C	Paga: nent o ant: If ary or		1 XBurial 2 ☐ Cremation 3 ☐ Removal from S 14 ☐ Donation 5 ☐ Other (Specify)	State		crematory or other place e Memori		07 Gre	envill	e,Alabama	
Baltimore,	permit. Departimontal		21. Signature of Funeral Service Licensee	2		22. Name and Address	^{ss of Facility} Ma: ford Roa	ad Baltin	neral more,Ma	Chapel,P.A ryland21214	
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death								
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Sign	w require been sig should b					-		1 ☐ Yes	2 □ No 3 □ P	obably 4 Hinknown	
Il Records,		Completed						24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of	
Vital	Attending Physicien: Th r death. ector: Atter this certificate by the funeral director, pag	Be c	25. Was case referred to medical examiner? Hospital:			Oth	200	h (Check only one)	- 50		
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<u>Š</u>	or Attendation death	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place buildin	of Injury - At hom ig, etc. (Specify)	e, farm	, street, factory, office		28f. Location (Street City or Town, Sta		ural Route Number,	
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	Ø		30. Name and address of person who completed cause	16,82	1/2	pe, Print)	BACT	TINES	e us	12/201	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 9 2007	ogistrar's Signatur	· State	parke					

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State of Maryland / Department of Health and Mental Hygiene 2007

		4	For State Registrar	Olato of Iviary	C	ertificate of l	Death	Re	eg. No.		
Physician /Medical			1. Decedent's Name (First, Middle, La		2. Date of D			3. Time of Death			
			Ruth Be11 4a. Facility Name (If not institution, giv	4b. City, Town, or	4b. City, Town, or Location of Death			8:30P W			
	Examin	er	100 S. Wiltshire			La Pla			Cha	rles	
26	Funeral Director		00, 20 ,00		n yrs. last birthda 90 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/21/1	Year) (irthplace (State or Foreign Country) Maine	
	and ww		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits	
	Maryl a-f sho fied a	ţċ	MD Charl	es	La Pla	ata				1 Yes 2 □ No	
-0030	or 28g	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What (Country?	
	sath w	eral	100 S. Wiltshire	2 Court 12. Was Decedent Eve	rin U.S. 1	20646 3. Was Decedent of H	ispanic Origin? (Sr	necify Yes or No-	USA 14. Race - An	nerican Indian,	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1,		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No		Rićan, etc.)	Black, Wh		
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7 0	e filed Il Hygi other ent, ti	Be Co	17. Father's Name (First, Middle, Last						Maiden Surname)		
yland	Menta Menta arked atic ev	To B	Guy L. Turney					. Bell T			
Baitimore, Mary	and 2 sho saith and 1 27 Is ma er traum		19a. Informant's Name/Relationship (Nancy Chicca/Daug	hter	100	So. Wiltsh		LaPlata,	Md. 2064	6	
	Pages 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetery, c	sposition (Name of crematory or other place $1d$ –Echo $1s$			20c.Location - City harlotte		
Balt	permit. Departn Importa any inju		21. Signature of Funeral Service Lice	CA / MI	00945	22. Name and Addre AREHART-EC				646	
ľ	*		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death								
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	/Medical Examiner		Due to (or as a consequence of):								
		ner	Sequentially list conditions, if any, leading to immediate	onsequence of):							
	ecutec and -transi	Examiner	Cause. Enter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last	cause (Disease or injury nat initiated events asulting in death) Last							
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_	ertificating phi	Medical	IF FEMALE:						1-3-		
C. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of Month	delivery Day Year	
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certifica completely filled in by the funeral director, I.	Medical Co	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of e and manner state	xamination and/o	leath occurred at the toor investigation, in my	ime, date and place opinion, death occi	e, and due to the ourred at the time, o	cause(s) and manne date and place, and	r as stated. due to the cause(s)	
	To the within 2 To the complet	⊠	29b. Signature and title of certifier	4.0	ar	29c. Licens	se number	29d. Date signed (M	onth, Day, Year)		
)			V. House	y		Do	0026	064	07-0	7-2007	
1	DB5		30. Name and address of person who VIDYASACAR 31. Date filed (Month, Day, Year) SEP 0 6	completed cause of dea	th (Item 23a) (Ty	Pe, Print)	1058 WHIT	3-THE	AINS, M	5-2007 GREEN BLY) D 20695	
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		1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Mar		rtificate of		,	Reg. No. 20	07	3007 3. Time of Death	
Physi		David C. Forman			Month August	h Day Year		1:15 P. N			
/Med Exam		4a. Facility Name (If not institution, give street and number)			4b. City, Town, o	or Location of Death		4c. County		1.13 1.	
h _i		7801 Orchard Gate	Court		Bethe	sda		Montgom			
Funera Directo			7. Age (In yrs. last birthday) 7. Trs.		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		(Month, Da	h y, Year) 1, 1936	Year) 9. Birthplace (State or For Country) 0hio		
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	rect	10e. Street and Number	J		10f. Zip Code			10g. Citizen of W	/hat Count	iry?	
3a or	Ö	7801 Orchard Gate C	ourt			817		U. :	S. A.		
IIIG Z IZ I 3-VU30 be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be Completed by Funeral Director	1 □ Never Married 2 🛣 Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Event Armed Forces? 1		1□Yes 2☒No		pecify Yes or No o Rican, etc.)	Black Specify.		etc. ite	
in 72 t	olete	15. Decedent's Educ (Specify only highest grade	completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	oation during most of wor d)	king	16b. Kind of Bu	siness/Ind	ustry	
Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	E	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	1	porate Ex			Reta	il		
0 = 0 %	Se C	17. Father's Name (First, Middle, Last)				18. Mother's Nan			e)		
should be file and Mental Hy marked oth	10	Jess Forman				Corri	ne Hirs	ch			
Mar nd 2 shc lith and 27 is m		19a. Informant's Name/Relationship (Type Thomas A. Forman -	_ '			and Number or Rue Lane, B				Code) 10817	
Dalumore, bermit. Pages 1 al Department of Hes mportant: If item any Injury or othe	,	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re	moval from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other pla	ce)	Date	20c. Location -			
Lant: Page	}	4 □ Donation 5 □ Other (Specify)				rance 9/2				Maryland	
Dal Sermit Depar mpor iny In	1	21. Signature of Funeral Service License	سد مد			gel Füner ville Pik				and 2085	
Physiciar /Medica Examine		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Metastat	e death. Do not ent ic Carcin consequence of):	er the mode of dyi	ng, such as cardiac	or respiratory a	rest,		Approximate Interval Between Onset and Death Months	
nted nsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	Due to (or as a o	consequence of):							
tificate be executed g physician and as the burial-transit	edical Exa	that initiated events resulting in death) Last	Due to (or as a c	consequence of):	equence of):						
that the death certificated by the attending phe detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							ry Day Year	
that bed by deta	y Ph	Part II. Other significant conditions conf	ributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use contr	ibute to th	e cause of death?	
w requires that been signed b	d by	1 Yes 2 No 3 Pi							3 ☐ Prob	ably 4ሺUnknow	
The law ate has b	Completed						24a. Was autop perfo 1∐ Yes	rmed? p	rior to con leath?	osy findings availabl npletion of cause of 2 X No	
VILCII siclan: T certificate rector, pa	Be	25. Was case referred to medical examiner?	ospital:		.t acinos Oth		th (Check only o	ne)			
Phy ral di	10	1 Yes 2 No	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatier 28b. Time o	IL 3 DOA	4 LI Nursing H		dence 6 Other)	
ending sa h. or After	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day)	/ear) Injury	M 1	rk? Yes 2∏No				I Pauta Numbar	
e Hospital or Att 24 hours efter de e Funeral Direct letely filled in by t		4 Homicide determined determined building, etc. (Specify)									
To the Hosp within 24 hor To the Fune completely fi	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	er: On the best of e and manner state	xamination and/or in	n occurred at the ti vestigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as st and due to	ated. the cause(s)	
To th Vithir To th	Me	29b. Signature and title of certifier	- m	77	29c. Licens	se number		29d. Date signed	i (Month, i	Day, Year)	
10		Lennell	Goto	10 (Itom 222) (Tues		D 7158		August 3			
		30. Name and address of person who cor Kenneth Goldstein	, M. D. F	.A.C.P. 5	530 Wisco	nsin Ave	nue, Sui	te 1125	, Che	ay Shase	

State Registrar 31. Date filed (Month Pay Year) 5 2007

32. Dyistrar's Signature

			State of Maryland / Department	artment of Hea Milificate of De	ılth and M eath		ene g. No 2 1) [7 31	0073
4			Decedent's Name (First, Middle, Last)			2. Date of Death	1	3. Tin	ne of Death
	Physicia		Harry Kenneth Frome			Month Septembe		Year 007 5:	15 P ^M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loca			4c. County of		
		40	817 Merry Go Round Way	Mt. A			Ca	arroll	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthplace (St Country)	
	Director		218-14-5944 82			Jan. 7,	1925	Maryla	ind
	and		Usual Residence of Decedent 10c. City, Town or Lo. 10a. State 10b. County 10c. City, Town or Lo.	ocation				10d. Insid	de City Limits
	Maryl f sho led a	0	Maryland Carroll Me	t. Airy				1 🙀	Yes 2 No
	the 28a-	Directo	10e. Street and Number	10f. Zip Code	-	10	Og. Citizen of Wh	nat Country?	
	3a or		817 Merry Go Round Way	21771			United	States	
	death ms 2 r mus	Funeral		Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Spe	ecify Yes or No-	14. Race	- American India	n,
5-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 X Married 1 No Yes 2 No	1 ☐ Yes 2 ☑ No S		nican, etc.)	Specify:	White, etc.	te
ğ	2 hou	Completed	15. Decedent's Education 16a. Dece	edent's Usual Occupation	n na most of worki		16b. Kind of Bus	iness/Industry	
2	thin 7	ple	(Specify only highest grade completed) (Give life. Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done durin DO NOT use retired)	ig most of worki	ng			
2	ed wi ygien rer th t, the	ő	4	Foreman			as and		c Co.
Maryland	be fill d oth even	Be	17. Father's Name (First, Middle, Last)	18.		(First, Middle, N)	
<u>Ş</u>	should be ind Mental marked o	မ	Archer Milton Frome, Sr.			Irene Z		~	
<u>a</u>	d 2 sho th and 7 is ma trauma			ing Address (Street and I Leafy Hollo					21771
	s 1 and 2 should be filed of Health and Mental Hygi Item 27 is marked other other traumatic event, <u>u</u>		9	osition (Name of ematory or other place)			20c. Location - C		
altimore,	Pages nent of l int: If Ite		INSURAL 2 Cremation 3 Removal from State		Septe	mber			
≣	permit. Pages Department of Important: If it any Injury or c			ark Cemeter 2. Name and Address of		auffer F	Baltimor		
B	Dep Imp any onc		8	E. Ridgevi	lle Blv	d. Mt.	Airy, Ma	aryland	21771
r			23a. Part1. Enter the dise se, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.					Interva Onset	kimate al Between and Death
,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a	- Cell	Cymp	home	~	14	ear
	Examiner		Due to (or as a representation of):		/ /				
RO	<i>U</i>	ē	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):						
	uted 1 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
Ć,	exec in and ial-tra	Exa	resulting in death) Last Due to (or as a consequence of):						
68760,	ficate be executed physician and sthe bunal-transit	edical	d						
	rtifica ng ph as th	Jed	IF FEMALE:						
Box	The law requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the bunal-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No No No No No No No No	□Ectopic pregnancy □ Other (specify)			23d. Date Mon	of delivery th Day	Year
P.O.	at the	Phy	9 Li Unknown		- D1	DO- Dida-			6
Vital Records,	v requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the u	Indenying cause given in	n Ραπ ι.	1 ☐ Ye	oacco use contril es 2 p No ∶	oute to the caus 3	
ပ္ပင္ပ	aw requir ss been s 2 should	Completed				24a. Was a	n 24b. W	/ere autopsy find rior to completion	lings available
ř	The lav	E				perform	med? / de	eath?	·
Ita	siclan: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	. 26	6. Place of Deatl	(Check only on			
<u> </u>	hysic his ce Il dire	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			me 5 Reside	ence 6 Othe	r (Specify)	
n O	ding Phys n. After this funeral di		27. Man of Death 1 Alatural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury	Work?		28d. Describe ho	ow injury occurre	ed	
Sio	Attending Physician: r death. ector: After this certifics by the funeral director. p	cati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury - At home farm of		s 2 □ No	00(1 1) (0)			
Division or	tal or At s after d al Direc	Certification:	4 Homicide 4 Homicide 4 Sound Not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office		28f. Location (St City or Town	reet and Numbe n, State)	r or Hural Houte	Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or is and manner stated.						ause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License nu	umber	2	9d. Date signed	(Month, Day, Yo	ear)
	Du.		le dru ino	DY	186	6 5	eptem	ber	1,2007
17	HIM,		30. Name and address of person who completed cause of death (Item 23a) (Type Kanan Hudhud, MD 46B	The mass of The	5 huser	a Dar	e Fre	derick	- mn
	Sta Regist		31. Date filed (Month, Day, Year) SEP 0 5 2007 SEP 0 5 2007	perk			, ,	<u>`</u>	
	gioti		OFI O C. T.						

		1	for State Registrar	otato of marytana /	Certificate of Death	Rec	g. No.	
			1. Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of Death
, i	hysici/ Medio/		Lester Will	iam Fraley		Sept. 04		11:59P M
<i>)</i> [Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	
			536 West Potomac		Brunswick inthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Frederic	
	ineral rector		5. Social Security Number 236–16–8149 Usual Residence of Decedent	7. Age (In yrs. last b)	Yrs. Months Days Hours Min.	June 21		lace (State or Foreign try) WV
land	M II		10a. State 10b. County	10c. City, Tov	wn or Location		1	0d. Inside City Limits
Mary	등	ţ	MD Frederic	k Brun	nswick			1X Yes 2 □ No
th the	or 28s	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Coun	itry?
ath w	238		536 West Poto	mac Street	21716		USA	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	od other than "natural", or items 23a or 28a-f show event, it a Medical Examinat must be multified at	y Funerai	1 ☐ Never Married 2 ☐XMarried	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No If Yes, Give	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecrfy Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
	at Ex	ed by	3 Widowed 4 Divorced	Year or Dates:	a. Decedent's Usual Occupation	11	6b, Kind of Business/Inc	
21 5-0036 ithin 72 hours af Je.	ledic ledic	olete	(Specify only highest grad	e completed)	(Give kind of work done during most of work life. DO NOT use retired)	ring	ob. Kilig of businessynk	Justry
Z1Z zwith ziene.	rither Frank	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Stone Mason		US Governm	ent
	othe vant,	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Mi	aiden Sumame)	
yland 2 ould be filed v Mental Hygie	Is marked other aumatic avant, I	ToE	Henry Neal Fr	aley	Virgi	nia Cathe	erine Swope	
Maryland 21 nd 2 should be filed wi	Is a	e 4	19a. Informant's Name/Relationship (Ty		b. Mailing Address (Street and Number or Rui			Code)
and and lealth	m 27 her tr	1	John W. Fraley		516 Currency Dr., Bun			State
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta	or of	l Ý	20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ F		ery, crematory`or other place)	-	Oc. Location - City or To	
Itiner	rtant	1	4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Fuyeral Service Licens		ant View Mem. Gar Sept	. 8, 0/	Martinsbur	g, WV
Ba Perm Depa	Impo any ir		SINGLE A	1/Main	John T. Williams F	uneral Ho	ome - Bruns	wick. MD
			23a, Part1. Enter the disease, or compl	ications that caused the death. Do	o not enter the mode of dying, such as cardiac			Approximate
Phys	sician		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.		1		Interval Between Onset and Death
	edical		disease or condition resulting in death)	Due to (or as a consequence	of):	rung		2 months
Exa	miner		Conventially list and disease	b				
ъ	Ħ	ner	Sequentially list conditions, if any, leading to interediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	a 0f).			
ecute	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	n of h		_	
60, 8 8 8	icien burial			Due to (or as a consequence	9 Ui).			
68760 ificate be e	ng physicien and as the burial-transit	Medical		d			1/	
. Box 68760, death certificate be executed	ttendir or use	Physician/Me	in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel deat 4 ☐ Pregnant at time of death	th 3 Ectopic pregnancy 5 Other (specify)	}	23d. Date of delive Month	ary Day Year
O ě	by the	hys	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown	/ /			
VITAL RECORDS, P.O	n signed by the a lid be detached f	þ	Part II. Other significant conditions con	ntributing to death but not resulting	in the underlying cause given in Part I.		acco use contribute to the	1
S ×	s been si	Completed				24a. Was an		psy findings available
The H	te has	E				autopsy perform 1 Yes 2	ed? death?	mpletion of cause of 2 No
ian:	is certificete ha director, page	Bec	25. Was case referred to medical		26. Place of Dea	th (Check only one		
		10	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/C		ome 5 Resider	nce 6 ☐Other (Specif	(y)
Division of Vita to Attending Physician: after death.	ther		27. Manner of Death ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑	28a. Date of Injury 28b. (Month, Day Year)	Time of Injury at Work? M 28c. Injury at Work? 1 Tyes 2 No	28d. Describe how	w injury occurred	
DIVIS al or Attu s after de	od in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
DIVISIO To the Hospital or Attendi	To the Funeral Diractor: After th completely filled in by the funeral	edical (29a. Certifier 1 XCertifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur	and due to the cau	use(s) and manner as s te and place, and due to	tated. o the cause(s)
To the	Toth	Me	29b. Signature and title of certifier	han in	29c. License number (23 23	29	d. Date signed (Month,	Day, Year)
FHI	M		30. Name and address of person who co	ompleted cause of death (Item 23a		~ ~/.		
	- CA		31. Date filed (Month, Day, Year)	32. Registrar's Signature	IN I CHOY WO	25423	5	
	Sta Registi		SEP 0 6 20		Specie			
DIME	7 Da 4 '0	201		7-3-3-3	7			- Carrier Company

DHMH 17 Rev 1/2001

State of Manyland / Department of Health and Mental Hygione 200

State of Maryland / Department of Health and Mental Hygiene? [] [] 7 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician FOOS 2105 M Marion Evelyn Gasdia 4ua /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Havre de Grace

If Under 1 Year | If Under 24 Hrs.

Months Days | Hours | Min. Harford Memorial Hospital Harford 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🕱 F Yrs. Director 032-12-8247 81 Nov. 30, 1925 Mass Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 2 should be filed within 7.5 mounts and Mental Hygiene.
7 is marked other then "natural", or fleme 23s or 28e-f ehow mounts event, the Medical Example must be notified at 10d. Inside City Limits 1 X Yes 2 No Directo Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 945 Nena Ave. 21078 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Noivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Victor Borelli Mary Teresa Scelzi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum Dominic R. Gasdia (Son) 945 Nena Ave. Havre de Grace, Maryland 21078 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Rock Run Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 08/22/2007 Havre de Grace, MD 21. Signature of Funeral Service Licensus 22. Name and Address of Pacifican Mitchell Smith Funeral Home 123 S Washington St. Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** EDSIS d /Medical Due to (or as a consequence of): Examiner KERA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ MODIN 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2√ No 1 ☐ Yes 2 ☐ No Vital within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 2 ER/Outpatient 3 DOA ð 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 8121107 066342 al 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Hospital HALFOLD 32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 1 9 2007 State Registrar

			1 - For State Registrar	State of Maryland /	Department of H Certificate of L			ene 200	7 30076
	- T	/	1. Decedent's Name (First, Middle, Last)			2	. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Iola Hinson			5	sep.	4, Year 200	7 03:00 AM
10	Examir		4a. Facility Name (If not institution, give sta	reet and number)	4b. City, Town, or			4c. County of Dea	th
			Citizens Care Cente	r.	Havre de			Harford	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	Months Davs	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day,)	(ear) 9. Bir	thplace (State or Foreign ountry)
b	Director		239-28-8349	85	Yrs.	Ma	vich 12,	1922 No	ountry) The Carolina
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Location		 -		10d. Inside City Limits
	Aaryli f sho ed al	ō	Married and Married	Da P A					1 X Yes 2 No
	the 128a-	Director	Maryland Harford 10e. Street and Number	Bel Ai	10f. Zip Code		100	g. Citizen of What Co	ountry?
	with sa or	٥	205 West Riding Dr.		21014			I.S.A.	,.
	ns 2%	Funeral		2. Was Decedent Ever in U.S.	13. Was Decedent of Hi	spanic Origin? (Speci	fv Yes or No-	14. Race - Ame	
10	r iter	Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 💢 No	If Yes, specify Cuba	n, Mexican, Puerto Ri	can, etc.)	Black, Whit	
036	urs a	þ	3 Nidowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No	Specify:		Specify: (1)/h	ite
21215-0036	72 ho	Completed	15. Decedent's Educa (Specify only highest grade	ition 16a	a. Decedent's Usual Occupa	ation	16	6b. Kind of Business	/Industry
21	e. an "r	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired,) most of working	I .		
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nd	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (I		aiden Surname)	
yla	Men Men arke	၉	Samuel King			Ila Green			
Maryland	2 sh and is m raum		19a. Informant's Name/Relationship (Type		b. Mailing Address (Street a			-	
6	and tealth m 27 her to		Joan H. Comer	20	15 West Ridin of Disposition (Name of	g Dr. Bel	Air, Ma	ryland 21	014
OF	ges 1 t of F if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🖪 Re		of Disposition (Name of ery, crematory or other place	⁹⁾ !			
Ë	tmen tant:		4 ☐ Donation 5 ☐ Other (Specify)		ind Mem. Park	9/7/20	07 R	lockingham	, N.C.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any futury or other traumatic event, the Medical Examiner must be notifiled at ance.		21. Signature of Funeral Service Licenses	00-11-					uneral Home
	<u> </u>		1 ×), X	12-4	123 S. Wash				
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	cause on each line.	// : A	g, such as cardiac or i	respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	<i>H</i> .	NEUMONIA				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):				
Ų.	LAGIIIIICI		Sequentially list conditions, b.	D 111	0				
	sit sd	Examiner	if any, leading to immediate cause. Leading to immediate cause. Cause (Disease or injury that initiated events	Due to (or as a consequence	e or):				
V.	and I-tran	хап	that initiated events c. resulting in death) Last	Due to (or as a consequence	ot).				
9	cate be executed physician and the burial-transit	ᄪ		240 10 (0) 40 4 00.100420.100	, 5.,,				
68760, <	phys the	dical	d.						
×	The lew requires that the death certifities the signed by the attending age 2 should be detached for use as	Physician/Me	IF FEMALE: 23	c. If yes, outcome pf pregnancy				23d. Date of de	livone
Вох	atten for u	cian	in the past 12 months?	1 ☐Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death	h 3 Ectopic pregnancy 5 Other (specify)			Month	Day Year
P.O.	that the de led by the a detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	Old Other (apeciny)				
σ.	that ed by deta		Part II. Other significant conditions conti	ibuting to death but not resulting	in the underlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds	sign d be	d by					1 ☐ Yes	2 No 3 P	robably 4 Unknown
Records,	w requires that seen signed I should be det	Completed					24a. Was an	Odb Wassa	utanau findinga availabla
Re	has ge 2	ם					autopsy performe	prior to	utopsy findings available completion of cause of
			Of Man and referred to and in-				1 Yes 2	No 1 ☐ Yes	ž ⊘ No
Vital		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	spital:	Othe	26. Place of Death (
9		H	27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/O 28a. Date of Injury 28b.	Time of 28c. Injury			ce 6 Other (Spe	ocify)
Division	ding Ph h. After th funeral	ţi	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		:? /es 2 ☐ No		,,	
S	Attend death. ctor: / y the f	lica	3 Suicide 6 Could not be	28e. Place of injury - At home, f			f. Location (Stre	et and Number or R	ural Route Number.
Ö	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	4 Homicide determined	building, etc. (Specify)			City or Town,	State)	
	spita nours nera rille			cian: To the best of my knowledg					
	e Ho 124 P e Fu letely	Medical	(Check only 2 Medical Examine one)	er: On the basis of examination a and manner stated.	nd/or investigation, in my o	pinion, death occurred	I at the time, dat	te and place, and du	e to the cause(s)
	Nithir Somp	Me	29b. Signature and title of certifier	10-1	29c. License	number	290	d. Date signed (Mon	th, Day, Year)
			Mumain &	L. Besnella.	M) 134	2800		9/4/15	7
	-		30. Name and address of person who con	poleted cayse of death (Item 23a)	(Type, Print)	4/	1/1	141101	4
	3		THOMAS A	1210NDO 3	19 S. UNION	ANY, A	La6.11	10. ,210.	78
	Sta	ite	31. Date filed (Month, Day, Year)	. Registrar's Signature	Snach 1	"	100	1	
	Registi	rar	SEP 1 9 2007	form in the	3				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	State of Maryla		tificate of L		R	eg. No. 2007	
Physic /Medi		Decedent's Name (First, Middle, Las ESTON	H.	НОЕ	'FMAN		2. Date of Deat Month August	30, 2007 Year	3. Time of Death 7:50 P M
Exami		4a. Facility Name (If not institution, give Kline Hospice	House	ro loot high deal	4b. City, Town, or Mount If Under 1 Year	-	8. Date of Birth	4c. County of Deat	lck
Funeral Director	1	5. Social Security Number 6. Security Number 212-12-9528 Usual Residence of Decedent		rs. last birthday) 2 Yrs.	Months Days	Hours Min.	Month, Day, DEC. 12	, 1914 Wes	thplace (State or Foreign buntry) t Virginia
ne Maryland Ba-f show itifled at	ctor	10a. State 10b. County Maryland Frede		City, Town or Lo	ick				10d. Inside City Limits 1 X Yes 2 □ No
th with the 23a or 24 ist be no	Funeral Director	10e. Street and Number 1632 Andover I	ane		10f. Zip Code 21702				ates
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once.	Þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 🕅 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		
/ithin 72 ho ne. han "natur e Medical B	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give life. I		during most of work d)	I	16b. Kind of Business. Dept. of A	
filed w Hygiel sther tl	e Col	17. Father's Name (First, Middle, Last)		DIO P	lant Open			Maiden Surname)	.т шу
2 should be filed wand Mental Hygie is marked other traumatic event, the	To Be		known			Lavina		Hartm	an
2 sho l and l is ma		19a. Informant's Name/Relationship (7			•			r, City or Town, State,	
1 and Health em 27 ther tr		Nancy C. Ray / Da 20a. Method of Disposition			Bethel sition (Name of natory or other place			Maryland 20c. Location - City or	Town, State
oermit. Pages 1 ar Department of Hea Important: If item 3 any Injury or other once.		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify) M	ount 01i	vet Ceme	tery09/05	5/2007	Frederick,	Maryland
permii Depar Impor any ir	de i	21. Signature of Funeral Service Licen	Belers	m 10		umtown Pi	ike/ Fre	Funeral Honderick, MD	21702
Physician	8 0	23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the done cause on each line.	eath. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory are	rest,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or a cons	sequence of):	<i>V</i>				
cuted od	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a con-	sequence of):					
ifficate be executed g physician and as the burial-transit	edical Exa	resulting in death) Last	Due to (or as a con	sequence of):					
death certiff e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pregnanc	у		23d. Date of de Month	blivery Day Year
' <u>दें</u> ठूल	þ	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use contribute t	o the cause of death? Probably 4 ☐Unknow
The law ate has b page 2 sl	Completed						24a. Was a autop perfor 1∐ Yes	sy prior to	utopsy findings available completion of cause of s 2 No
Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		t 3E DOA Oth	26. Place of Dea		HOS	SPICE HOUSE
ine ine	ion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 1 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury	f 28c. Inju	4 LI Nursing H		lence 6 X Other (Sp.	в сіїў)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral preserved.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		At home, farm, streecify)			28f. Location (S City or Tow	Street and Number or F vn, State)	Rural Route Number,
e Hospital 24 hours e Funeral etely filled	ledical Co		ysician: To the best of my niner: On the basis of exar and manner stated.						
To th within To th	Me	29b. Signature and title of certifier	W)		29c. Licens	se number		29d. Date signed (Mor	nth, Day, Year)
10		30. Name and address of person who	completed cause of death of the completed cause of death of the complete cause of the complete cause of the complete cause of death of the complete cause of the cause	(Item 23a) (Type,	Print)	Then.	on AV	Fredenic	x mp
S Regis	tate trar	31. Date filed (Month, Day, Year)	32. legistrar's S	ignature A	and I	J POT-	-/-		0470

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Anna May Heffner 2007 2:00 A September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Golden Living Center Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 x F 78 220-26-5748 Aug 9 1929 Director Brunswick, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at MD Frederick Brunswick 1 ▼ Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r 21716 120 4th Avenue USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☎ No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Air Pac Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Production Line Supervisor Frederick, MD permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Franklin Heffner Ellinda Nell Dinterman ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curtis L. Cooper, Cousin 118 4th Avenue, Brunswick, MD 21716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify)

21. Signal of real Series License

Barbara A. Williams, Owner Park Heights Cemetery 9/5/07 Brunswick, MD 22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary embolus - hilatoral **Physician** MONTHS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-tran Due to (or as P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 □ Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 1∐ Yes 2 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records,

ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t

filled in by the

4 Homicide 29a. Certifier (Check only one)

29b. Signature and Title of certifier

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

D0062223

29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

BS LARWM, MD 196, TJ DLIVE, FREDFLICK, MD 30. Name and address of

BOCARUM MD

State Registrar

Medical

To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HENWOOD Day LOUISE O7 4:15 A M **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK BOURNE FREDERICA GAST If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 9 - 21 - 1937 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗹 F 136-30-530 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 Yes 2 No FREDERICK MD FREDERICR Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number BOURNE 21702 UJ A 1024 GAST Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. "natural", or iten edical Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DEFENSE College (1-4or 5+) Elementary/Secondary (0-12) ANALYST LOGISTICES traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental WILSON WILLIAM LONA WILEY P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BOURNE CT. FREDERICK MD 21701 HENWOOD 1024 EAST Thomas item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State New Jan. 20a. Method of Disposition 500r 307 Department of Important: If it any Injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State BRIDIGADE GON. WILLIAM C. DOYLE VET COM. ARNEYTOWN 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 6 ARY L. ROLLINS FUN. IKME Herry X FREDBRICK MD 21701 110 WEST SOUTH ST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARI **Physician** hours /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 I Inknown 9 Unknown has been signed by ge 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 → bhknown Curen Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autonsy page perform 1 Yes 2 certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician:

Saltimore, Maryland 21215-0036

State

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

SEP 0

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

			1 – For State Registrar		Marylar		artment of F rtificate of			Reg. No. 20	
	Physici: /Medic		1. Decedent's Name (First, Middle, I ROBERTA LO		HNSON	1			2. Date of De	BER ^y 11 Y	3. Time of Death 3:50a M
	Examin		4a. Facility Name (If not institution, g Talbot Wing			_	4b. City, Town, o Cheste	rtown		4c. County of Kent	
	Funeral Director		077-14-9032	Sex 7. 1 ☐ M 2 🖾 F	Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		rs. 8. Date of Bir in. (Month, Da May 11	y, <i>Year</i>) 9	. Birthplace (State or Foreign Country) Arizona
	faryland show ed at	o	Usual Residence of Decedent			ty, Town or Lo					10d. Inside City Limits 1 2 Yes 2 □ No
	be filed within 72 hours after death with the Maryland Hygliene. driber than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 318 West Wil	200	CII	estert	10f. Zip Code 2162()		10g. Citizen of Wha	at Country?
	er death items 23 her must	uneral	11. Marital Status	12. Was Decede	197	J.S. 13. \			(Specify Yes or No lerto Rican, etc.)		American Indian, White, etc.
5-0036	hours aft ural", or i	by	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Date		46	1 ☐ Yes 2 █ X No dent's Usual Occup	Specify:		Specify:	White
-6121	within 72 lene. than "nat he Medica	Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)	College (1-4	or 5+)	(Give life. L	kind of work done of NOT use retired	during most of v d)	working		
and 2	be filed tal Hygid d other event, th	To Be Co	17. Father's Name (First, Middle, La Charles Wood	,		1101	memaker		Name (First, Middle,	Own Ho Maiden Surname)	ome
>	should ind Men marke	2	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street		Brown Rural Route Numb	er, City or Town, Sta	ate, Zip Code)
Z Z Z	and 2 lealth a m 27 is		James A. John	son (s	son)		Box 1!	54 Ch		1, MD.	
ıtımore,	Pages 1 ent of H nt: If ite ry or otl		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ato	cemetery, crer	sition (Name of matory or other place of oury Cem		^{Date} 22/07	20c. Location - Cit	dyville, MD.
Balti	permit. Pages 1 and 2 should be Department of Heatil and Menta Important: If item 27 is marked any injury or other traumatic es once.		21. Signature of type fel Service Life	ensee	л М0051	10 G	Name and Addre alena F 18 West	ss of Facility 'uneral Cross	Home o		en L. Schaec D. 21635
	Physician	8 6	23a Part Enter the disease, or co shock, or heart failure. List or Immediate Caus (Final disease or con Jion	emplications that cau ly one cause an eac	sed the dea h line.						Approximate Interval Between Onset and Death
8/00,	/Medical Examiner physician and the prival-transit	dical Examiner	Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or d.	as a consec	quence of):	nis (
O. Box 6	he death certificate the attending phys ched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outco 1 ☐Live birt 4 ☐Pregnan 9 ☐ Unknow	n 2∐Fet tattime of	al death 3□	Ectopic pregnancy Other (specify)	/		23d. Date of Month	•
II Kecords, P.	The law requires that the death certifica ate has been signed by the attending prage 2 should be detached for use as the	Completed by Ph	Part II. Other significant condition	^	_		nderlying cause giv	en in Part I.	1 ☐ 24a. Was auto	Yes 2 No 3 an 24b. We pricy dea	ute to the cause of death? Probably 4 Unknown re autopsy findings available of to completion of cause of the cause
VITa	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inp	atient 2 [] ER/Outpatien	at 3D DOA Oth	or:	Death (Check only o	one) dence 6 □Other	(Pagaibi)
sion or	nding Physician: The lav th. :: After this certificate has s funeral director, page 2	\vdash	27. Mauner of Death Natural 5 Pending 2 Accident investigat	28a. Date of (Month,		28b. Time of Injury	f 28c. Injur Wor			how injury occurred	(Эреспу)
DINIS	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 28e. Place of	injury - At h , etc. <i>(Spe</i> c	nome, farm, str ify)	eet, factory, office		28f. Location (City or Tor		or Rural Route Number,
	ne Hospit 24 hours ne Funers pletely fille	Medical (29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the becaminer: On the base and manner	s of examin	owledge, deatl ation and/or in	h occurred at the ti vestigation, in my o	me, date and pl opinion, death o	ace, and due to the occurred at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
)	To the vithing to the composition of the compositio	Ň	29b. Signature and title of certifier	e X			29c. Licens	e number	301	29d. Date signed (I	Month, Day, Year)
	4+1		30. Name and address of person when Michael Peime	er, M.D.	122	Spee	Print) r Rd. C			21620	
	Sta Registr		31. Date filed (Month, Day, Year) SFP 1 9 2	007 Reg	istrar's Sign	ature Apa	di				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Geraldine Vivian Johnson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner VURSING If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number **Funeral** Months Days Min. 1 □ M 2 🔀 F Jan. 11. 1922 Director 212-16-2603 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Havre de Grace Maryland Harkord 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21078 1001 Chesapeake Dr Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify White Specify: 3 ₩Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George M. Bearham Loretta Jeffers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline A. Davies (Daughter) 1001 Chesapeake Dr. Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Poplar Grove Cem. 08/21/07 Phoenix, Maryland 21. Signature of Funeral Service Livens 22. Name and Address of Ellman Mitchell Smith Funeral Home 123 S Washington St. Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner vance Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 100 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 TPNo 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 687602

sician and burial-trans signed by the attending physician d be detached for use as the buria cate has been sig , page 2 should b within 24 hours after death.

To the Funeral Director: After this certific.
completely filled in by the funeral director,

r 28a-f show notified at

d other than "natural", or items 23a or event, the Medical Examiner must be

within 72 l

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other trainment"

Baltimore, Maryland 21215-0036

To the h

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

Atrash Anas 31. Date filed (Month, Day, Year) State SEP 19

4 ☐ Homicide

(Check one)

and title of cartifier

29a. Certifier

29b. Signature



2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Doo6 2903

29d. Date signed (Month, Day, Year)

08/20/07

Havre De Grace MD 21078

Physician /Medical Examiner

Funeral Director

nould be filed within 72 hours after death with the Maryland 1 Mental Hygiene.
narked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at To Re Commissed by Firneral Director

permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: If Item 27 is marked other it
any injury or other traumatic event; Ith

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Margaret T. Kimmel 4a. Facility Name (If not institution, give street and number) Gaithersburg Wilson Healthcare Center Montgomery 8. Date of Birth (Month, Day, Year, Sept. 17, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Year) Months Days Hours 1 M 2 X 89 1917 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Montgomery Village Maryland Montgomery 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20517 Beaver Ridge Road 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify. Specify: ģ 3 Widowed 4 □ Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4or 5+) 12 Statistical Typist Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian G. Franklin Isidor J. Nau 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 12204 Horse Center Road, Gaithersburg, MD 20878 Gary Kimmel/ Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Gate crematon er other place) August 31, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD 4 Donation 5 Dother (Specify Cemetery 2007 STIVET SPITING, IND
22. Name and Address of Facility DeVol Funeral Home, 10 East 21. Signature of Funeral Service Deer Park Drive, Gaithersburg, MD 20877 Ver the di 23a. Part1. En ase, or complications that caused the e. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) One Week Sepsis Due to (or as a consequence of): Myocardial Infarction Two Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hypertension Years Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 □Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2XNo 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2**X** No 1 Yes 2□ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) August 30, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raman R. Tuli, M.D., 10810 Darnestown Rd., #202, Gaithersburg, Maryland 20878

State

Registrar

31. Date filed (Month, Day, Year)

5 2007

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(and

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2007 Month **Physician** 2300 ALEX KONTOS /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner 1 Dicomica Regional Medical Center Salishu if Under 1 Year | If Under 2 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Security Number **Funeral** 1√ M 2□ F 241-48-4264 76 10, 1930 Director Nov. Greece Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Frederick Middletown 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 8891 Hawbottom Road U.S.A. 21769 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Entrepreneur Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Konstantine Kontogiorgos Theodora Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theoni Kontos / Wife 8891 Hawbottom Road, Middletown, Maryland 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □Removal from State St. Nektarios 9/3/07 Emmitsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livenses ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intraconnial /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by to d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24a. Was an autopsy performed? 1☐ Yes 2 ♠ No Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 25 No 1 Inpatient 2 1 Tes 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Natural

Accident Injury 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760, within 24 hours at To the Funeral D

> State Registrar

one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP

04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

218

Registrar's Signature

29c. License number

HO0 561

SALLE

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 ner fh 8886 12-17-08 by Health and Mental Hygiene Certificate of Death Reg. No. UU / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** September 4, Kerfoot 2007 2030 Bartlett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Havre de Grace Harford Memorial Hospital Harford 5. Social Security Number 6922 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6 Sex 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠M 2□F New York Director 80 1926 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location 1 ☐ Yes 2X No Director Maryland Cecil Conowingo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 408 Basin Run Road 21918 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Four Years Chemical Engineer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brant Price Kerfott Henretta Bartlett 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Kerfoot 210 Lower Hopewell Road, Oxford, Pennsylvania 19363 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☒ Removal from State Evans Eagle Crematory 09/07/07 Leola, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalure of Funeral Service Licen se 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 Monran Approximate Interval Between On at and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ettending physicien and for use as the burial-transit Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? ۵ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ★ 10 1 Yes Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient Medical Certification: To 1 Tes 2 ER/Outpatient 3 DOA 28c. Injury at Work? ate of Injury (Month, Day Year) 28b. Time of 27. Manner of 28d. Describe how injury occurred Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

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Box 68760

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29b. Signature and title

32 Registrar's Signature

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ath (Tem 23a) (Type, Print) FURFORD MEMORUL

29d. Date signed (Month, Dey, Year,

Registrar

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Certification: To within 24 hours after death.

To the Funeral Director: / 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBER 4, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8186 LARK BROWN ROAD, ELKRIDGE, MD 21075 Geller 31. Date filed (Month Day Year) 32. Poistrar's Signature 5 2007 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

DHMH 17 Rev 1/2001

		ı	For State Registrar	State of N	Maryland / Dep Ce	artment of			giene 007	30087
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	Funeral			Sex 7.7	Age (In yrs. last birthda		r If Under 24	Hrs. 8. Date of Birt Min. (Month, Da 03/28		Birthplace (State or Foreign Country)
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	pu 🛊 🖫		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	ocation				10d. Inside City Limits
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ŏ	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow In Medical Exercine for collined	ted	15. Decedent's	Education	16a. Dec	edent's Usual Occ	pation		16b. Kind of Busines	ss/Industry
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Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 II ony Injury or other tra ance.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from Stat	20b. Place of Dis cemetery, cr	oosition (Name of ematory or other p	ace)	Date	20c. Location - City	or Town, State
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3ali	permit. Pa Departmen Important: eny Injury		21. Signature of Vineral Service Lio	Contract of	CC0442	22. Name and Add Beeson	ress of Facility Tunera	1 Home of	f Newark	
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38760,	icate be executed physician and s the burial-transit	dical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	as a consequence of):			,		
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>	Physician: this certific al director,	To	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa	tient 2 ER/Outpati	ent 3 DOA	ther: 4 Nursi	ing Home 5 Resid	dence 6 Other (S	ресіfy)
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Division of	in the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place of the building,	njury - At home, farm, s etc. <i>(Specify)</i>			City or Tou		
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	To t	Σ	29b. Signature and title of certifier				nse number		29d. Date signed (Mo	- · · · · · · · · · · · · · · · · · · ·
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	1		30. Name and address of person who NARAYANA RAO	v- PULA	death (Item 23a) (Type IIB NOM	Print) H SMeet	, ELKT	OM, MO		
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 6	2007 32. Refis	strar's Signature	Goods				

			For		State of M	/larylan		epartment			1ental Hy	giene		
			= State Registrar					Certificate	of De	ath	2. Date of De	Reg. No.	2007	30088
	Physicia /Medic	an	1. Decedent's Nam	ne (First, Middle, Las	McKa	Y					Month	Day	Year Zou =	3. Time of Death 3:4 P M
	Examin	-	11	If not institution, give		A .	ı			cation of Death		4c.	County of Deat	th
			Universit	1	yland M			hday) If Under 1		Under 24 Hrs.	8. Date of Bi	rth	0.8:	the lane (Chate on Francisco
	uneral irector		5. Social Security 8		ex M 2□F	Age (In yrs. 74				lours Min.	(Month, D	ay, Year)	Co	thplace (State or Foreign ountry) Lrginia
	25/11/		Usual Residence								17 07 =			
ırylan	show d at	_	10a. State	10b. County		10c. City	y, Town	or Location						10d. Inside City Limits 1 ☐ Yes 2 X No
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with ti	a or 2 be n	Ē	10e. Street and Nu		± D3			10f. Zip C		17.57			zen of What Co	
eath	ns 23 must	Funeral	11. Marital Status	Prospec	12. Was Deceder	nt Ever in U.	S.	13. Was Decede		L154 anic Origin? (Sp	ecify Yes or No		14. Race - Ame	
after d	or Iten			ried 2 Married	Armed Forces	s?			_		Rican, etc.)		Black, Whit	e, etc.
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ld be	ked c	To Be	Wil	lliam	T.	M	cKa	y Sr.		Mary		Ei	chelbe	erger
Lat y rail of Later of the Cooper 2 should be filed within 72 hours after death with the Maryland and Manjal Houlene.	s mai		19a. Informant's I	Name/Relationship (Type. Print)	_	19b.	Mailing Address (Street and	Number or Rui				Zip Code) 29576
and 2	n 27 i ier tra			E. McK	ay Jr.	(Son	-	9 Bear				·		Let, S.C.
ges 4	If Iter		20a. Method of Di: 1 ☐ Burial 2	sposition Cremation 3	Removal from Sta	re i		Disposition (Name y, crematory or oth			Date		cation - City or	
t. Pay	tant:			5 ☐ Other (Specif		Ca:	rro	ll Crem						
permi	Deportment or near in marked other than "natural", or Items 23a or 28a-f show important: If Item 27 is marked other than "natural", or Items 27 is marked other than Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of F	uneral Service Lice	isee	Hill .		22. Name and						Maryland ne, P.A.
			23a. Part1. Enter	the disease, or comeant failure. List only	plications that cays	ed the deat	h. Do n						ar mon	Approximate Interval Between
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/M	ledical		disease or conditi resulting in death)	a. Due to (or	as a conseq			// Cer					
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ath cer	tendir r use	an/N	IF FEMALE: 23b. Was deceded		23c. If yes, outcor 1□Live birth			3 □Ectopic pre	gnancy			1	23d. Date of de Month	elivery Day Year
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F = E	age 2	omp									per	opsy formed? 2 ☐ No	death?	
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Ing P	After t		27. Manner of De 1 ☑ Natural	5 Pending		Injury <i>Day Year)</i>			Bc. Injury at Work?		28d. Describe	e how inju	ry occurred	
VISION Attending	tor: /	icati	2 ☐ Accident 3 ☐ Suicide	investigatio 6 ☐ Could not b	e 290 Place of	iniury - At h	ome fa	rm, street, factory,		s 2□No	28f Location	(Street ar	nd Number or F	Rural Route Number,
A P	aller Direct	Certification:	4 ☐ Homicide	determined	building	, etc. (Speci	fy)	, 555,,			City or T	own, State	e)	idia Hodio Hambor,
Hospita	within 24 hours alter death. To the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	Medical C	29a. Certifier (Check only one)		hysician: To the be miner: On the basi and manner	s of examin								
o the	omple	Med		nd title of certifier	1	otatou.		○ 29c.	License n	umber		29d. Da	te signed (Mor	nth, Day, Year)
- :	0		•	X	#		MI	V) Au	4171	A 3551	8086	9	19/200	7
	00		30. Name and ad	dress of person who	completed cause of	of death (Ite	m 23a)	(Type, Print)					1	
	25		Donald	Sulliva	n 27	2 S.	9	rene S	+	Balty	nor,	MD	2120	
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07-07085 Troy

y Matthews 1- For State	State of Maryla	Certificate of	Health and Ment	Reg. N	
edical Examiner TROY M	Name (First, Middle,Last) IATTHEWS			2. Date of Death Month Da September 12	3. Time of Death 0403 hrs 4c. County of Death
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Funeral 5. Social Security 216–94	nty rtained	7. Age (In yrs. last birthday) 40 Yrs	Months Days Hours	er 24Hrs. 8. Date of Birth(No. CIOBER 2	9. Birthplace (State or Foreign WASHINGTON, DC Country)
	ce of Decedent 10b. County	10c. City, Town or Locat		E 7.03	10d. Inside City Limits 1 XYes 2 No
noa. State MARYLAN 10e. Street an 7504 PU 11. Marital Sta	d Number	PORT WASHING	10f. Zip Code 20744		Citizen of What Country?
after death with the Maryland 10e. Street au 7504 PU 11. Marital Sta 1 X Never I 3 Widow 3 Widow	Married 2 Married Armed Fo	orces?	as Decedent of Hispanic Ori res, specify Cuban, Mexican	gin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
3. Widow 15. Deceden 17. Deceden 2. Deceden 2. Deceden 3. Widow 15. Deceden 17. CR 17. CR 18. CR 18. CR 19.	nt's Education (Specify only highest grant/Secondary (0-12) College (1)	de completed) 16a. Decede during r	Yes 2 X No specify nt's Usual Occupation (Givenost of working life. DO NO	kind of work done	Sb. Kind of Business/Industry CONSTRUCTION
O T Eathor's N	ADE Name (First, Middle, Last)	LABOR	18.Mothe	er's Name (First, Middle, Mai N PATRICIA MATTH	den Surname)
C lad a significant	nt's Name/Relationship (Type, Print) Y TOLSON / SISIER	7504 F	UIT ROAD, FORT	WASHINGTON, MARY	er, City or Town, State, Zip Code) LAND 20744 20c. Location - City or Town, State
20a. Method	of Disposition 2 Cremation 3 Removal f ion 5 Other Specify:	from State ST. CHARLES	CEMETERY	SEPT.17,2007	GLYMONT, MARYLAND
Baltimore Baltimore Department of H Important: If is 1 X Bright Dougt TANA Dougt TANA	of Funeral Service Licensee	m583 34	39 LIVINGSION R		, MARYLAND 20640
dical Immediate Cor condition	resulting in death) Due to (or as	1, cocaine and met			Between Onset and Death
if any, leading cause. Ente	ng to immediate Due to (or as underlying Cause	s a consequence of):			
box 68760, the death certificate be executed only the attending physician and ched for use as the burial - transit 17 Associatory Medical Ex. Physician/Medical Ex. Annual Physician American Ex. Annual Physician American Ex. But II. Other	cedent pregnant in the amonths?	egnant at time of death 5		opic pregnancy	23d. Date of delivery Month Day Year
Boot if Other	er significant conditions contributing	known g to death but not resulting in th	ie underlying cause given in	1 Yes	n 24b. Were autopsy findings available prior to completion of cause of
cian: The law certificate has ector, page 2 s (Comp.) Be Comp.			26.Place of De	perform 1 Yes 2 ath (Check only one)	
The state of the s	es 2 No 28a. Da (Mc	Inpatient 2 ER/Outpati ate of Injury onth, Day,Year) 28b. Time	ent 3 DOA Other; of Injury 28c. Injury at W	Nursing Home 5 1/ork? 28d. Describe h	Residence 6 Other: now injury occurred sed drugs and alcohol
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be deace only the funeral director, page 2 should be deace only the funeral director, page 2 should be deace only the funeral director, page 2 should be deace only the funeral director, page 2 should be deace only the funeral director, page 2 should be deace only the funeral director, page 2 should be deace only the funeral director, page 2 should be deace only the funeral director, page 2 should be deace only the funeral director, page 2 should be deace only the funeral director, page 2 should be deace only the funeral director of the funeral director, page 2 should be deace only the funeral director, page 2 should be deace only the funeral director, page 2 should be deace only the funeral director, page 2 should be deace only the funeral director of the funeral director	cide 6 Could not be determined (Spec	Place of Injury - At home, farm, s city) found at home	street, factory, office building	g, etc. 28f. Location (\$ or Town, \$ 1812 Map1	street and Number or Rural Route Number, City tate) e Lane Accokeek, MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: Completely filled in by the Good Certific (one) Medical Certificati Medical Certificati Signal Sign	Certifying Physician: To the 2 Medical Examiner: On the base and manner	best of my knowledge, death o sis of examination and/or inves er stated.	ccurred at the time, date and tigation, in my opinion, deat 29c. License num	n occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
S 29h Signar	ture and title of certifier	allah mo	O.C.M.E.		September 13, 2007
B		cause of death (Item 23a) sistant Medical Examine 2. Registrar's Signature	111 Penn Street	, Baltimore, MD 2120	1
State 31. Date fil	ed (Month SEP eq.) 4 2007 32	Z. Registral's Signature	000401		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Las 2. Date of Death **Physician** Month 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sligo Creek Nursing Home Takoma Park Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 ☐ M 2 😿 F Days Hours Director 578-50-1389 9.7 3, 1910 South Carolina March Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23e 10700 Huntwood Drive Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
snt: If item 27 is marked other than "neturel", or items 23 Lry or other traumatic event, It a Modical Examinar must Funeral 20901 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 Alo 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced Specia White Year or Dates: leted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Compl Elementary/Secondary (0-12) College (1-4or 5+) Buyer Department Store Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Monroe Dusenbury Effie Rilla Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James H. Monroe/Son 2808 Hardy Avenue, Wheaton, Maryland 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of importent: If any injury or once. Hillsboro Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Sept. 6, Hillsboro, Virginia 2007 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approxi Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neu **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Physician/Medical Exam Due to (or as a consequence of): Box 68760 the IF FEMALE for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ pe 4. Unknown the funeral director, page 2 should Be Completed 1 ☐ Yes 2 ☐ No 3 🗌 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Beath (Check only one) Hospital: Other: Certification: To 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient this 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours To the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 0 29b. Signature and title of certifia 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who co of death (Item 23a) (Type, Print) 0 31. Date filed (Mog Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30091 Reg. No 2 0 7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Miller Joseph Francis Sr. August 29,2007 12:40 ppm 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Charlotte Hall Veteran's Home Charlotte Hall St.Mary's 8. Date of Birth (Month, Day, Year) 1/11/1918 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days Hours New York 1**⊠**M 2□F 326-24-8118 89 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 X No Montgomery Damascus MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20872 USA 24408 Clubview Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc 1 XYes 2 No 1941 − If Yes, Give Year or Dates: 1962 1 Never Married 2 Married White 1 ☐ Yes 2 🔼 No Specify: 3 ₩ Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S.Army Corpsman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Catherine Doxey John Henry Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24408 Clubview Drive Damascus, Md. 20872 John Henry Miller/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Tar Burial 2 ☐ Cremation 3 Removal from State 9/06/2007 Bushnell, Florida Florida National 4 □ Donation 5 ☐ Other (Specify) Funeral Service Licen 21. Signature of PHILIP OC. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Sayamous Immediate Cause (Final disease or condition resulting in death) ancer Cey Ca Head and Due to (or as a consequence of): to (or as a consequence of): If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 K No ongestive muopath 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner Examiner

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certificate has

After this

within 24 hours at er death.

To the Funeral Director: A completely filled in by the formal completely filled in by the formal completely filled in the formal

funeral director,

Hospital or Attending Physician:

P

Physician/Medical

Be Completed by

Medical Certification: To

Physician

/Medical

Examiner

Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be nonce.

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

notified

Director

Funeral

Be Completed by

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

1 ☐ Yes 2 No 27. Manner of Death

28a. Date of Injury (Month, Day Year)

1X Natural 5 Pending investigation 2 Accident

28b. Time of 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29b. Signature and title of certifier

D45092

29d. Date signed (Month, Day, Year)

30. Name and address of person wy com. cause of death (Item 23a) (Type, Print)

Rarul S Jani, rince Frednck

State Registrar

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygien 30092 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** August 29, 2007 8:40 P.™ C1eo Grace Marzo /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery National Lutheran Home Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2X F Yrs. 85 June 24, 1922 Illinois Director 339-14-7696 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 XYes 2 ☐ No Directo Washington, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20015 United States 3613 Military Road, N.W. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours atter Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or ite any Injury or other traumatic event, the Madical Examina 2010. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify δ 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Financial Manager Department of the Navy 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Otis Whittler Durham Essie Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9603 Low Meadow Drive, Gaithersburg, MD. 20882 Thomas Wischnowski/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/5/2007 Rockville, Maryland Parklawn Mem. Park 22. Name and Address of Facility DeVol Funeral Home Surreture of Funeral Service Licens 10 East Deer Park Dr., Gaithersburg, MD. 20877 Approximate Interval Between On, et and Death 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or a tilline. Immediate Cause (Final disease or condition resulting in death) Prysician Reun /Medical (ir as a consequence of) Examiner eavi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine signed by the ettending physician and dispersion be detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to seath but not resulting in the underlying cause given in Payt I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2□ No 1 Yes 2 - No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA s after deam.
el Director: After th 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number le Cerres 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles W. Karesh, M.D., 26033 Ridge Road, Damascus, Maryland 20872 31. Date filed (Month, Day, Year) 5 FP - 5 State Registrar

DHMH 17 Rev 1/2001

Amend Item #26 #4 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Cecil County Health State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 7 For State Registrar 09/12/07 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 2007 11:45A^M 1, Sept. Milbourne Jane /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil City Chesapeake Nebo Road 716 Mt. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/7/1927 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2X P Yrs. 79 222-14-4597 Delaware Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State 28a-f ahow aust be notified at 1 ☐ Yes 2 ☐ No Directo New Castle Newark DE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 19711 USA 112 Elm Avenue 238 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. the Medical Examiner: 1 ☐ Yes 2 No 1 Never Married 2 Married 5 1 ☐ Yes 2 ☑ No Specify: Specify: White If Yes, Give Year or Dates: ۵ 215-003 3 XWidowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Window Repair Clerk 8 2 7 is marked other 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) it. Pages 1 and 2 should be riment of Heelth and Mental Joseph McCullin Regina Fraer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19806 Heelth I 1713 N. Rodney Street Wilmington DE Important: if itam 27 any injury or other tronce. Frank G. Milbourne - Son Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/5/07 New Castle Gracelawn Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens CC0442 CC0442 Beeson Funeral Home of Newark, 2053 Pulaski Highway, Newark, the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, ell Approximate
Interval Between
Onset and Death 19702 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physicien and s the burial-transit or Attanding Physician: The law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Completed by Physician/Medical attending for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 5 Other (specify) 4 ☐ Pregnant at time of death 1 ☐ Yes 2 ☐No Ö 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 NO After this certificate funeral director, peg Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 - Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA - 6√Other (Specify) Daughter 1 ☐ Yes 2 ☐ No ပို 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner Death 28b. Time of 28c. Injury at Work? Certification: Injury s after decrei Afr 1 - Tatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled: 1 bertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Pay, Year) 29b. Signature and hitle of certifier no

State Registrar

DHMH 17 Rev 1/2001

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Dimon

31. Date filed (Month, Day, Year) SEP 1 2 21

MD

32. Registrar's Signature

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Lisa Nadine Mitch			or Print in Bla of Maryland /	Departme	ent of He	alth and I			jible.			
		I- For State Registrar 1. Decedent's Name (First, Middle,Las	4\	Certifica	ate of De	ath	1,	Re 2. Date of Deat	g. No. 2	007	3 D	09;
Physician Medical Examin	44	1. Decedents Name (First, Middle, Las	Lisa Na	dine N	4itche	11		Month 28 August 27	Day Ye	1	0707 hrs	
		4a. Facility Name (if not institution, giv			4b. Ci	y, Town, or Loc lumbia	ation of Death	·	4c. County Howard			
Funeral		Social Security Number 6. Security Number		(In yrs. last birt		Inder 1 Year		8. Date of Birt	h(MM/DD/YYY		ace (State or	
Director		215-04-5298 1 Usual Residence of Decedent	M 2XF	3 () Yrs. M	inths Days	.Hours Min.	Augus	t 11,1			
Maryland 28a-f show any d at once,		10a. State 10b. County Maryland Hov	ward	10c. City, Town		olumbi	.a			,	d. Inside City L Yes 2X	
Maryla Maryla 28a-f dator	~ L	10e. Street and Number			10f.	Zip Code		10	g. Citizen of W	-	?	
h the l	ﻕ▮	11018 Wood El					21044		U.S.Z			
Imore, MD 21215-0036 Pages I and 2 shouldbe filed within 72 hours after death with the Maryland ment of Health and Méntal Hygiene. Itani: If item 27 is marked other than "naturals", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2	Ever in U.S.	If Yes, sr	ecify Cuban, M	iic Origin? (Spe exican, Puerto F			e - American te, etc.	Indian, Black,	
rhl", o	by F		If Yes, Give Year or Dates:			2 X No s				Blac		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", nijury or other traumatic event, the Medical Examples.	ed	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	nly highest grade comp College (1-4 or 5-				(Give kind of wo NOT use retire		16b. Kind of B	usiness/Indu	stry	
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21215-0036 Judybe filed within 7 I Mental Hygiene, marked other than ic event, the Midter		17. Father's Name (First, Middle, Last)					Mother's Name (•		
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MD 2 should 2 should and 1 m 27 is reaumatic	-	Angela A. Mit		87					lumbia			2104
Te, No. 1 and Health	- 1	20a. Method of Disposition		20h Diago	f Diagonition	Name of cemeto Ice) Park	ery,	Date	20c. Location	- City or Tov	vn, State	
altimore, mit. Pages I a partment of He portant: If ite		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify.		Colu	mbia N	Park Lemoria	al 9_1	5-07	Clark	svill	e.Mar	vlar
Balti bermit. Departir Imports njury o		21. Signature of Funeral Service Licen			22. Name	and Address of	Facility Mar	zullo	Funer	al Ch	apel,	P.A.
	-	23a. Part I. Enter the disease, or comp	United that caused to	he death. Do no	16009	Harfo	<u>rd Roa</u>	<u>d</u> Balt	<u>:imore</u>	,Mary	land2	121/4
Physician /Medical		failure. List only one cause on ea						, sopmatory and	21, 21, 2011, 31, 11		Between Onset Death	
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	₽.	Co. Chisease or injury that initiated							mil	(1)		
	ш	events resulting in death) Last d.	Due to (or as a consec	quence of):								
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68760, certificate be nding physici	ě,	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome				1950		23d. Date of	of delivery		\neg
c 68 1 certif ending use as	cian	past 12 months?	1 Live birth 4 Pregnant at to	ime of death			Ectopic pregnan	icy	Month	Day	Year	- 1
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Rec		25 Mice				26 Place of	Death (Check or	1 Yes	2 No	1 🗸 Yes	2 N	<u> </u>
/ital	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	lospital: 1 Inpatien	t 2 ER/O	utpatient 3	DOA Oth	OF:		Residence 6	✓ Other: So	ene	
of \ of Phy ig Phy iffer thereal		1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Ye	y 28b.	Time of Injury	28c. Injury a	t Work?	28d. Describe I	ow injury occur	rred		
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n 24 hou ee Funer letely fil	<u>8</u>	20- Cartifies	an: To the best of my	knowledge, dea	ath occurred a	the time, date a	and place, and cath occurred at	due to the caus	e(s) and manne and place, and	er as stated. due to the ca	ause(s)	
출 등 등 일 :			and manner stated.									

State Registrar

Joans

Assistant Medical Examiner

38 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD.

O.C.M.E. OCME

111 Penn Street, Baltimore, MD 21201

August 29, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Sep 11, 2007 Nines 1:25am Bettv Lee /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Beverly Living Center of Cumberland Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 4, 1924 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 K Days Hours ΜD 220-16-6321 82 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at MD Allegany Cumberland 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21502 USA 109 Race Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ XIo Specify. Specify. 2 3 X Widowed 4 □ Divorced Year or Dates: white Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) than permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other trainmant. Nursing Assistant Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles L. Moore Mary M. (Weaver) Moore 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry Nines 505 Pamela Drive Newport News VA 23601 son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Hurial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Memorial Park 9/14/2007 MD Cumberland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . Enter the disease, or complications that caused the death. Shock, or heart failure. List only one/cause on each line. Immedial. Cause (Final disease condition resulting in death) Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical (or as a consequence of) Due to Naphno selvosis Examiner rleanine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the as use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records. completely filled in by the funeral director, al or Attending Plater death. To the Hospital within 24 hours a To the Funeral C

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Medical

31. Date filed (Month, Day, Year) State SEP 19 Registrar

29b. Signature and title of certifier

29a. Certifier

m.O 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

GUPTA

GRS KENTAVE. CUMB., MD 21502

📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

00033280

29d. Date signed (Month, Day, Year)

Sept 12,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Comfort Njafuh August 26,2007 12:49p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** none Director 56 Cameroon Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exembler must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Cameroon 941 Bonifant Street #3 20910 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Njafuh Frieda Kanda P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co22) 910 19a. Informant's Name/Relationship (Type. Print) Bobga Emmanuel Ayaba/Nephew 941 Bonifant St. #3 Silver Spring, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 ■ Removal from State 9/15/2007 Bali, Cameroon Bali, Cameroon 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of heral Service Licen PHILIP D.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEP SHOCK Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner AUTOIMMUNE DEFICIENCY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

ACUTE PENAL Examine Que to (or as a consequence of): HUPERKALEMIA Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2X No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlansit completely filled in by the funeral director, page 2 should be detached for use as the burlansit Division or Vital Records, P.O. Box 68760,

Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-59284 MIMMARE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

31. Date filed (Month, Day, Year) 2007

SHAHID SHAMIM, MD, WASHINGTON ADVENTIST ASPTAL, TAKOMA PARIL, MD -20012 32, Raistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Harold Oxenburg September 2007 12:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Holy Cross Hospital Montgomery 6. Sex Birthplace (State or Foreign Country)
 DC 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1270711909 1 ★ M 2 □ F 97 Director 579-40-3995 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director Silver Spring Maryland | Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12325 New Hampshire Avenue 20904 United States Funeral 14 Race - American Indian Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeping Accounting traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Harry Oxenburg Sophie Rubia ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Oxenburg / Nephew 3006 Fayette Rd. Kensington, MD 20395 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State King David Cemetery 109/08/200/ Restaurant Sons Inc. 9 4 ☐ Donation 5 ☐ Other (Specify) 09/08/2007 Falls Church, Virginia 21. Signature of Ineral Service Linense Mo 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Urosepsis and Myocardial Infarction 24 Hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it as a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Prostate Cancer, Bladder Cancer, Colorectal Cancer, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ※※No 24a. Was an Dementia, Hypertension page 2 s autopsy 2 🔯 No Physiclan: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔀 Inpatient Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Injury 1 🛚 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 ☐ Could not be 3 Suicide n 24 hours after de ne Funeral Directo pletely filled in by ti 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 deficiency Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title, 09/04/2007 D31001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500 Greenway Center Dr. #430 Greenbelt, MD 20770 J. Turkewitz MD Stuart distrar's Signature

State Registrar

			State of Maryland	-	artment of H rtificate of I		lental Hyg	iene	
		п	Registrar 1. Decedent's Name (First, Middle, Last)	Cei	unicate of t	Deam	2. Date of Deat	eg. No. 2007	3 0 0 9 3. Time of Death
	Physicia		Ossman Buhl Orndorff, Jr.			,	Month August 3	Day Year 1, 2007	8:04 am
3	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death	<u> </u>	4c. County of Death	
	and the supplier of the supplier of		Holy Cross Hospital		Silver If Under 1 Year	Spring If Under 24 Hrs.	0 D-4 (D) 4b	Montgo	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Ia 234-60-5038	as <i>t birtnd</i> ay) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) Cou	place (State or Foreign ntry)
			Usual Residence of Decedent				Sept. 3	•	st Virgini
	arylan show d at	_	10a. State 10b. County 10c. City,	, Town or Lo	cation				10d. Inside City Limits 1,□Yes 2□No
	the Ma 28a-f	Director	Maryland Montgomery 10e. Street and Number	R	ockville 10f, Zip Code		T 4	0g. Citizen of What Cou	****
	with t				, , , , , ,		'		ritry ?
	death ms 2; r mus	Funeral	207 Woodland Road 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	S. 13. ¹	Was Decedent of H) Ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Ameri	
õ	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show adical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No		1 ☐ Yes 2 ☐ No	Specify:	nican, etc.)	Black, White, Speci Whit e	
5-0036	hours tural"; al Exa	ed by	3 ☐ Widowed 4 🖾 Divorced Year or Dates: 1958 –	-61	A.A. dent's Usual Occup	ation		16b. Kind of Business/Ir	
<u>.</u>	be filed within 72 ho tal Hygiene. d other than "natu event, the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done of NOT use retired	during most of worki d)	ing	TOD. KING OF EGSINESS/II	idusti y
7 7	d within giene.	Com	12	Sta	tion Mana	ger		Public Tran	sportation
yland	be filed tal Hygi d other event, ti	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			-
	d Men narke	은	Ossman Buhl Orndorff, Sr.	101 14 17		Doris Op			
Ma	d 2 sh th and th sn traun		19a. Informant's Name/Relationship (Type. Print) Wesley Dennis Orndorff/Son					, City or Town, State, Zi _l antown , MD	,
	les 1 and 2 should be of Health and Mental of Health and Mental if item 27 is marked or other traumatic ever		20a. Method of Disposition 20b. Pla	ace of Dispo	sition (Name of matory or other place)ate	20c. Location - City or T	
Ë	Pages nent of int: If its					Cemetery 2		lintonville	. WV
saitimore,	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licensee	2 7	Name and Addre	ss of Facility ins		Home Inc.	
	0 5 5 0 0		Jans & Vosay					ilver Sprin	
		0.0	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Septicemia	. Do not ent	er the mode of dytr	ig, such as cardiac d	or respiratory arre	est,	Approximate Interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence)	ence of):					
	Examiner			01100 01).					
	± q	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mury that initiated events	ence of):					
	ecute and trans	Examiner	Cause (Disease or injury that initiated events c c	once of):					
8/60,	icate be executed physician and s the burial-transit		Due to (of as a consequence	erice or).					
20	ificate g phys	edical	d						
X Q Q	w requires that the death certifi been signed by the attending I should be detached for use as	Physician/M	IF FEMALE: 23c. If yes, outcome pf pregnart 1 □ Live birth 2 □ Fetal		Ectopic pregnancy	,		23d. Date of deliv	
ה מ	e deal	sicie	in the past 12 months?		Other (specify)	<u> </u>		Month	Day Year
Ţ.	that the		Part II. Other significant conditions contributing to death but not result	Itina in the u	nderlvina cause aiv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ecords,	uires l signe Id be	d by	Metastatic Renal Carcinoma		,g g		1 □ Ye		bably 4 ☐Unknown
Ş	law req as been 2 shou	Completed					24a. Was at	n 24b. Were aut	opsy findings available
r	e i e	omp					autops perforr 1□ Yes 2	y prior to co ned? death?	ompletion of cause of
VITA	iclan: Th certificate ector, paç	BeC	25. Was case referred to medical examiner?			26. Place of Death			2 110
2	hys lgiis	To	1 ☐ Yes 2 【X No Hospital: 1 【X Inpatient 2 ☐ E			4 Linursing Ho		ence 6 Other (Speci	ify)
	ding Phy h. After thi funeral	ion:	1 ☑Natural 5 ☐ Pending (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 ∐No	28d. Describe ho	w injury occurred	
UNISION	Attend death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined building, etc. (Specify,	me, farm, str			28f. Location (St	reet and Number or Run	al Route Number,
5	al or al al or al al or al Dire	Certification:	4 ☐ Homicide determined building, etc. '(Specify,)			City or Town	, State)	
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After t completely filled in by the funera		29a. Certifier (Check only 1 ☐ Certifying Physician: To the best of my know 2 ☐ Medical Examiner: On the basis of examinati	vledge, deat	h occurred at the tir	ne, date and place,	and due to the cared at the time. d	ause(s) and manner as	stated.
	the H hin 24 the F mplete	Medical	one) and manner stated. 29b. Signature and title of certifier		29c, Licens			9d. Date signed (Month,	
	4 4		Landau & Wile M	D		061937		8/3//	
	10+1		30. Name and address of person who completed cause of death (Item	23a) (Type.				70,7	m.D
			CANDACE L. WILSON, N	10-		REST 6	LEN RD	SILVER SI	PRING 20910
j	Sta		60 6						
DH	Registr MH 17 Rev 1/20		SEP - 5 2007	B. A	Society.				
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Division or Vital Records, P.O. Box 68760,

9 LI Unknown				
Part II. Other significant conditions of MYECOFI BLOST () BSCPHACEAU	ontributing to death but not resi	ulting in the underlying	g cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
ESC PHACEAR	VARIER			24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical			26. Place of De	eath (Check only one)
examiner? 1 ☐ Yes 254 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 []	DOA Other: 4 Nursing	Home 5 Residence 6 □Other (Specify)
27. Manner of Ceath 1		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) **Eartifying Ph 2 Medical Example 1	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occurre tion and/or investigati	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)
29b. Signature and litle of certifier	Correr mp	2	29c. License number 10 31 76 /	29d. Date signed (Month, Day, Year) 9/14/2007

10:35

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 ☐ Yes 2 ☐No

State Registrar

Medical Certification: To

funeral

completely ₹ L

hin 24 hours after death the Funeral Director:

M. . Registrar's Signature Date filed (Month, Day, Year)

9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA 501

			1 - State Registrar		Certificate of Death Reg. No. 2007 3010				30101		
1	Sit W		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath		3. Time of Death
н	Physici /Medic		Dorothy	G. R	obinson			Septemb	er 3,	Year 2007	12:00 p M
V	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	or Location of Death			inty of Death	
		4	Manor Care-Potom	ac		Poto	mac		М	ontgom	ery
-124	Funeral		5. Social Security Number 6. S		n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h Year)	9. Birthp Coun	lace (State or Foreign
	Director		175-48-3197	¹ □M ² M F 95	Yrs.	Widness Days	Tiours With.	Aug. 2			nsylvania
	and w		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	cation				1	0d. Inside City Limits
	Mary f sho	ō	Market Montre	ma 1877	D	- t - m					1★ Yes 2 No
	the rotif	Director	Maryland Montgo 10e. Street and Number	mery	Р	otomac 10f. Zip Code			10g. Citizen	of What Coun	itry?
	3a ol	0	10714 Potomac	Tennis Lane			20854			USA	
	ms 2	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13. V		lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No		Race - Americ	
9	after or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give				Hican, etc.)		Black, White,	
5-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	d by	3 Widowed 4 □ Divorced	Year or Dates:		☐ Yes 2√√No	Specify:		Spe	ecify: Whi	te
5-	s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene. Item 27 is marked other than "naturithen traumatic event, the Medical	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Deced	lent's Usual Occup kind of work done	oation during most of work d)	ing	16b. Kind o	f Business/Inc	dustry
121	e filed within al Hygiene. I other than ' vent, the Me	d l	Elementary/Secondary (0-12)	College (1-4or 5+)			a)		_	=	
121	filed v Hygie other t		12 17. Father's Name (<i>First, Middle, Last</i>)	Ho	memaker_	18. Mother's Name	- (First Middle		n Home	
anc	should be f and Mental I s marked of umatic eve	Be	William S. Grim				Sarah E			,	
Ž	should be nd Menta marked matic ev	ပ	19a. Informant's Name/Relationship (10h Mailin	a Address (Street	and Number or Run				Cada
Maryland	nd 2 sho alth and 27 is ma ir trauma		Douglas J. Robins				on Spring				*
é,	1 and 2 Health tem 27 i		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date		on - City or To	
<u>0</u>	Pages nent of int: If it		Burial 2 Cremation 3	Removal from State	Rolling G	natory or other pla reen Cem	etery Sep			-	
altimore,			4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice)		22	. Name and Addre	ess of Facility			· · · · · · · · · · · · · · · · · · ·	nnsylvania
B	permit. Departr Importa any inju		James 50	Janhar	F	rancis J	. Collins				
	*		23a, Part1, Enter the disease, or com	plications that coused the	e death. Do not ente	OO Unive er the mode of dyi	rsity Blvd ng, such as cardiac	or respiratory a	ilver rest,	Spring	Approximate
1	Physician		shock, or heart failure. List only immediate Cause (Final		d Dementi	-					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a co		4				_	
	Examiner										
		je l	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):						
	certificate be executed ding physician and se as the burial-transit	Examiner	Cause (Disease or injury that initiated events	C							
0	e exe ian al ırial-t		resulting in death) Last	Due to (or as a co	onsequence of):						
68760,	ate b hysici	/Medical		■ d							
9 X	e as t	Mec	iF FEMALE:							-	
Bo			23b. Was decedent pregnant in the past 12 months?	23c. if yes, outcome pf p 1 ☐ Live birth 2 ☐	☐Fetal death 3 ☐	Ectopic pregnanc	y			Date of delive Month	ery Day Year
	ne de the a	Physiciar	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	ne of death 5∟	Other (specify) _					24, 104,
P.0	ires that the de signed by the a be detached i		Part II. Other significant conditions	contributing to death but n	ot resulting in the ur	iderlying cause giv	ven in Part I	23e. Did to	obacco use c	contribute to the	ne cause of death?
or Vital Records,	law requires that the death as been signed by the atter 2 should be detached for u	d by	•	,	3	, , ,				o 3□ Prob	
Ö	w requir been s should	Completed						04-14	T ₀		X
He G	has has	ld m						24a. Was autor		prior to cor	psy findings available mpletion of cause of
a	iclan: The certificate harector, page							1□ Yes	2 X No	1 ☐ Yes	2 □ No
V:t	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deatl	, , ,			
0	Physician: r this certificaral director, I	2	1 Yes X No	1 ☐ Inpatient	2 ER/Outpatien	3 DOW	4 Mursing Ho	me 5 Residence Residence Residence Section Residence Res			V)
on	ffe	io	1X Natural 5 ☐ Pending	(Month, Day Y		Wor	rk? Yes 2□No	Zou. Describe i	low injury oc	surred	
S	I or Attending after death. Director: Afte I in by the fune	lica	3 Suicide 6 Could not b	e 280 Place of injune	- At home, farm, stre			28f. Location (5	Street and Nu	ımber or Rura	al Route Number,
Division	i ji fe q	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tov	vn, State)		
	To the Hospital within 24 hours a To the Funeral I completely filled			nysician: To the best of n							
	ne Ho n 24 h ne Fu	Medical	(Check only 2 ☐ Medical Examone)	miner: On the basis of ex and manner stated	amination and/or invol.	estigation, in my	opinion, death occur	red at the time,	date and pla	ce, and due to	the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	76		29c. Licens	se number		29d. Date siç	gned (Month,	Day, Year)
	10		ple ple			D	0054566		Septe	mber 4	, 2007

DHMH 17 Rev 1/2001

State Registrar 14702 Cherry Leaf Terrace, Silver Spring, MD 20906

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Sunitha Bhogavilli, 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 06:26 AM Dr. Herman Arnold Robbins 07 25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Centu Hicomics Regional SALISBUTH TENINSULA Medical If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 17€MM 2 . F 105-36-7130 96 6/12/1911 NY Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show 'natural", or items 23a or 28a-f shov dical Examiner πust be notified at 1 ☐ Yes 2 X No Director MD Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4860 Powell School Rd. 21849 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No 2 Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Physician Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic evenoce. Anna May Chanin Eron J. Robbins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1559 Teal Dr., Ocean City, MD 21842 Dr. Geoffrey H. Robbins / son Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/6/2007 4 ☐ Donation 5 ☐ Other (Specify) Eastern Shore Vet. Hurlock, MD ral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonitis **Physician** Diration /Medical Due to or as a consequence of): Examiner vanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Examiner that initiated events resulting in death) Last burial-tra Due to (or as a consequence of) Box 68760, physician attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Division or Vital Records, P.O. 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably : After this certificate has been si funeral director, page 2 should it Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed es 2 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2₩No Certification: To 1 ☐ Yes 1 npatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Mannet of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation 2 🗌 No 1 ☐ Yes 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify)28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

BA4+1

105-36-7130

State Registrar

Anupama Varadasajan 31. Date filed (Month, Day, Year)

SEP 06

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 E. Carroll St. Salisbury, MD 21801

29c. License number

D0063991

07-06873	
locauplino	Boarro

acqueline Roque	State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Reg. No. 2007 3010								
Physician/ Medical Examiner	Ackalin Elizabeth Roque September 4, 2007								
Wedical Examiner	4a. Facility Name (if not institution, give street and number) Holy Cross Hospital 4b. City, Town, or Location of Death Silver Spring 4c. County of Death Montgomery								
Funeral Director	5. Social Security Number N/A 6. Sex 1 M 2XF 10 Yrs. 16 Under 1 Year 16 Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 17 Salv								
and resource markets are already as an income	Usual Residence of Decedent								
d de any	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No								
with the Maryland us 23a or 28a-f sho pe notified at once.	10e. Street and Number . 10f. Zip Code . 10g. Citizen of What Country?								
th the Nath	11973 Andrews Street 20906 E1 Salvadore 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14: Race - American Indian, Black,								
er death	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 No specify E1 Salvador 1 X Yes 2 No specify E1 Salvador 1 X Yes 2 No specify E1 Salvador								
hours aft natural" Examine									
5-0036 led within 72 hours tygiene. other than "natur the Medical Exam Completed I	Elementary/Secondary (0-12) College (1-4 or 5+) Student Education								
- 'N 3 2 5 7	Antonio Cruz Elsa Roque 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 94544								
MD 12 sh th and 127 i	Anna Roque/Grandmother 711 Berry Avenue, Apt231 Hayward, California								
Baltimore, permit. Pages 1 and Department of Heal Important: If item injury or other fra	1 Burial 2 X Cremation 3 Removal from State crematory or other place)								
altim mit. Pa partinen portant	4 Donation 5 Other Specify: Roselawn Crematory 9-12-07 Livermore, Californ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility								
	23a. Part I. Enter the disease, ir complete disease, in complete disease								
Physician /Medical	failure. List only one cause on each line. Death Death								
xaminer	or condition resulting in death) Due to (or as a consequence of):								
ēr	Sequentially list cenditions, b. Bowel obstruction If any, leading to immediate Due to (or as a consequence of):								
kecuted kecuted transit transit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CRectal trichobezoar Due to (or as a consequence of):								
50, te be execut ysician and : burial - tra	X UNPENDED X AMENDED								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Ex	IF FEMALE: 23c. If yes, outcome of pregnancy 1								
the deat	1 Yes 2 ✓ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?								
P.O. es that the signed by be detach	1 Yes 2 ✓ No 3 Probably 4 Unknown								
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tal Relician: The certificate rector, pa	25. Was case referred to medical 20. Face of Death (Creek only one)								
f Vit Physic er this er To E	1 Ves 2 No limitation 2 Page 1 Injury 28c. Injury at Work? 28d. Describe how injury occurred								
on o ending ath. or: Afte the fune	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No								
Division ospital or Attending hours after death. Ineral Director: After filled in by the function:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide 1. Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Division of Vital Rec To the Hospital or Attending Physician: The h within 24 hours after death. To the Fineral Director: After this certificate b completely filled in by the funeral director, page. Medical Certification: To Be Com									
F 3 F 8 6									
	O.C.M.E. September 5, 2007 30. Name and address of person who completed cause of death (Item 23a)								
V, 1	Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
State Registra									

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1 - For State Registrar

			State Registrar		Cer	tificate of L	Death	Re	eg. No. 2	107 3	nink
g Wa	Physicia		1. Decedent's Name (First, Middle, La: WILLIAM HARR	JR.			2. Date of Death Day Year 3. Time of Death Day SEPTEMBER 10 2007 10:00 ^M				
/Medical Examiner 4a. Facility Name (If not institution, g			4a. Facility Name (If not institution, giv Union Hospital	e street and number)	4b. City, Town, or Elkton	Location of Death				-	
21	Funeral		5. Social Security Number 6. S	N7		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Mar 10		9. Birthplace (S Country)	_
2,52	Director	13	220-28-0316 Usual Residence of Decedent	75 2 3 4 5 5	Yrs.			Mar 10	1932	Marylar	ıa
	aryland show dat	_	10a. State 10b. County MD Kent		y, Town or Lo						de City Limits]Yes 2 ∑ No
	the M 28a-f notifie	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?				
	h with 23a or st be	al Di	325 West St.		2165	1	U.S.A.				
ဖွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 May Yes 2 □ No 19 If Yes, Give	52	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2점 No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		ce - American India ack, White, etc. fy: White	
Ö	hours tural"; al Exa	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates: -19	16a. Dece	dent's Usual Occup	ation		16b. Kind of E	Business/Industry	
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Maryland	uld be fil Mental H Irked ott Itic even		17. Father's Name (First, Middle, Last William Harry		•			:lizabet			
Jan	l 2 sho and l is ma rauma		19a. Informant's Name/Relationship (Anna Buzzard	Type. Print) (daughter)		ng Address (Street S West S					
ē,	Healt Healt tem 27		20a. Method of Disposition	20h. F	Place of Dispo	sition (Name of matory or other place	i			- City or Town, Sta	ate
E E	Pages nent of nt; If it		1⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (<i>Speci</i> .	Themoval from State Ca	lena	Cemeter	y 9/1	4/07	Galen	a, MD.	
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Scrvice Dice	MO05	10 G	alena F 18 West	ss of Facility Uneral Cross	Home of St. Gal	Step ena,	hen L. MD. 216	Schaech 35
Г	7		23a. Part1. Enter the disease, or com shock, or heart failure. List only		h. Do not ent	er the mode of dyin	ng, such as cardiad	c or respiratory arr	est,	Appro Interva Onset	ximate al Between and Death
	Physician /Medical		Immediate C se (Final disease or andition resulting in death)	a. SEPTIC		OCIL	6 ME	UMUN	In A	ILDS 2	24 day
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P.O. Box	law requires that the death certi as been signed by the attending 2 should be detached for use a	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		⊒Ectopic pregnancy □ Other (specify) _	y	23d. Date of delivery Month D			Year	
	s that ined by e deta		Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	ren in Part I.		,	ntribute to the caus	se of death?
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<u>e</u>	n: The lificate har, page		25. Was case referred to medical	erlipidem	ie_	ムてエ	26 Place of De		2 No	1 ☐ Yes 2 ☐ N	0
Ž	Physician: r this certificaral director,	To Be	examiner?	Hospital: Impatient 2	ER/Outpatier	nt 3□ DOA Oth	or.	Home 5 ☐ Resid		ther (Specify)	_
0 0	ding Physician: The h. h. After this certificate ha funeral director, page		27. Manner of Death 1☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe h	ow injury occu	urred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	e 28a Place of injuny - At h	ome, farm, sti		Yes 2 □ No	28f. Location (S City or Tow	treet and Nun	nber or Rural Route	e Number,
	ital or irs afte ral Dir led in l										
	e Hosp 24 hou e Fune letely fi	Medical	29a. Certifler (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.								ause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	1		29c. Licens	se number		29d. Date sign	ned (Month, Day, Y	ear)
•	. 4		30. Name and address of person who	completed cause of death //ter		Print)		30	1116	2101	-
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DI	JML 17 Day 1/2				-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Michele LaRue Stevens September 11, 2007 4:42 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hagerstown Washington Washington County Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F Months Days Hours 57 Director 214-54-0334 March 25, 1950 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, i'm Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Completed by Funeral Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 536 Beaver Creek Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tannery 12 Factory Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Domaruk LaRue Frances Settles ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David E. Stevens (Husband) 536 Beaver Creek Road Hagerstown, Maryland 21740 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State September Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 13, 2007 Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home M01414 12525 Bradbury Ave. Smithsburg, Maryland 21783 AVIS 100 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and the burial-tra resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 PM 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Hipatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 ☐ Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral C Hospital 1 🕒 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)
September 11th, 2007 29b. Signature and title of certifier 29c. License number an, as D625&& 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Antietum Sh He pershown 251. E. JUDITH MBAOUA, MD 31. Date filed (Month, Day, Year) Registrar's Signature

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State Registrar

2007

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Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wrobelewski, M.D., 6001 Muncaster Mill Road, Rockville, MD

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

September 2, 2007

20855

Physici /Medic Exami

Funeral Director

	Please	Type or Print					-	_	ible.		
	For 1 _ State	State of Ma	•	•			fental Hyg	jiene			
_	Registrar			ertifica	te of De	eatn		eg. No.	107	30107	
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	163-22-2762 Usual Residence of Decedent	1 M 2 □ F	(In yrs. last birth	Month		Hours Min.	(Month, Day Aug. 27	, ^{Yea} [) 927	9. Birthp Coun	lace (State or Foreign try) PA	
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tor	D.C. None Washington, D.C. ¹\X\Yes 2□No										
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ge (17. Father's Name (First, Middle, Las	t)			18		e (First, Middle,		me)		
2	Thomas A. Scanl	on				Sara Ar	n Mille	r			
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	4 □ Donation 5 □ Other (Spec		Holy Se	pulche	r Cem.	20	07 ° F	lochest	er, N	ew York	
	21. Signature of Funeral Service Lie	nsee		22. Name	and Address o	of Facility De	Vol Fune	ral Ho	me		
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	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	one cause on each line	the death. Do no	t enter the m	ode of dying, s	such as cardiac	or respiratory arr	est,		Approximate Interval Between	
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Completed by Physician/Medical E		d									
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N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p		3 □Ectopic	prognancy			23d. D	ate of delive	ery	
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Me	29b. Signatura and title of certifier 29d. Date signed (Mor							ed (Month.	Day, Year)		
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	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						.ug. JI	, 200	,		
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State Registrar 32. Rajistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 3, 2007 12:37 PM Gloria В. Unger 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Year 20 1 ☐ M 2 😾 F Poland 579-14-6838 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 TYYes 2 □ No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20895 U. S. A. 3616 Little Dale Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 Xidowed 4 Divorced 16a. Decedent's Usual Occupation 16h, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Sales Associate Saks Fifth Avenue 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Isaac Bobrow Blume Wasserman 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 621 Still Creek Lane, Gaithersburg, Maryland Jaime A. Schaechter Grand Dgt. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Memoval from State 4 Donation 5 Other (Specify) King David Mem. Gdns | 9/5/2007 Falls Church, Virginia 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 21. Signature of Funeral Service Licenses Donald 23a. Part1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUM Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant. 3 ☐ Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

ģ

Completed

Be

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any Injury or other traumatic event, the Medica once.

72 hours after

Baltimore, Maryland 21215-0036

Examine

been signed by the attending physician and should be detached for use as the burial-tran Physician/Medical à Completed funeral director. Be ို Certification: To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A

Records,

Division or Vital

nder

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

27. Manner of Death 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8218 70 KAUF 31. Date filed (Month Cay Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** September Kelly Lynne Vogel 1:45 P.M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington 999 Security Rd. Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 4, 1969 5. Social Security Num 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🛛 F 37 182-56-4398 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Hagerstown 1 ☐ Yes 2X No Director Md. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 999 Security Rd. U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes : 2 No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify: White Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Custume Designer Theatre 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John D. Vogel Katherine L. Maloney ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 15365 Norwood Ave. P.O. Box239 Blue Ridge Summit, Pa. Katherine L. Vogel (Mother) 17214 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Sept.1外 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Smithsburg, Md. Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. M01414)avis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1e tastatic Immediate Cause (Final Cervical Cancer Squamous Cell UNKNOWN disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 □ Yes 2 □ No

The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Division or Vital Records, P.O. Box 68760, signed to has or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician

Examiner

/Medical

3altimore, Maryland 21215-0036

Examine Physician/Medical Completed Be 2 Certification: To the Hospital o within 24 hours aft To the Funeral Di

2 Accident

3 ☐ Suicide 4 ☐ Homicide

(Check only one)

29a. Certifier

6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

0058181

29d, Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 324 E. Antietam St. #306 Hagerstown MD 21740 PEPRAH

31. Date filed (Month, Day, Year)

32. Registrar's Signature Elegen J.

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** $7:30 a^{M}$ Ruth Van Tuyl September 1, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Kensington Park Retirement Community Montgomery Kensington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6 Sex **Funeral** Months Days 1 M 2 X F 31, 578-40-8218 82 March 1925 Washington, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 XNo Director Maryland Montgomery Kensington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20895-3434 USA 3618 Littledale Road, #203 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White altimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Bureau of Elementary/Secondary (0-12) College (1-4or 5+) Standards/US Government Chemist 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Hugh Latimer Dryden Mary Libbie Travers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Department of Health a Important: If item 27 is any injury or other train 8435 Brook Road, McLean, Virginia 22102 Hugh L. Van Tuyl/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 6, Sept. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2007 Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. James S 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Congestive Heart Failure /Medical Due to (or as a consequence of) Examiner Chronic Obstructive Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Hypertension burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical Atrial Fibrillation the IF FEMALE use 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s autopsy performe 1 Yes 21 No Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 | Yes 2√€ No Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) 10 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide in 24 hours.
the Funeral Directory filled in by determined 4 Homicide 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the P within 24 To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

12

DHMH 17 Rev 1/200

6320 Democracy Blvd., Bethesda, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Segistrar's Signature

Ajay Reddy, M.D.

5

31. Date filed (Month, Day, Year)

September 4, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month September 8, 2007 **Physician** ROBERT WARREN 7:00 A M . T /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yea Mar 30, 19 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 229 - 26-7730 1 XM 2 □ F 78 DC Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at PA 1 ☐ Yes 2 No Director Adams Fairfield with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "~-* any injury or other traumant." 6 Barbara Trail 17320 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No White <u>م</u> Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Gas company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harvey Warren Bessie Eustace ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Florence M. Warren 6 Barbara Trail, Fairfield, PA 17320 20c. Location - City or Town, State
Liberty TWP 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Fountaindale Union Cem 09/11/07 4 Donation 5 Other (Specify) Adams Co., 22 Name and Address of Facility Grove-Dowersox Funeral Home, Inc 21. Signature of Funeral Service Licensee 50 S. Broad St., Waynesboro, PA 17268 James U. Dewerson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition CANCETE METASTATIC PRIMANY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offi-Physician/Medical Examiner use as the burial-trar Due to (or as a consequence of): attending physician for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performe 2 **N**0 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 211 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manne Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Latural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760 or Attending Physician: Hospital

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To the Funeral C

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neral Director: A
filled in by the fu

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Medical

State Registrar

DIBTE A 31. Date filed (Month, Day, Year)

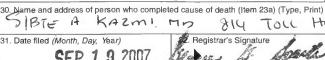
KAZMI

SEP 1 9 2007

29b. Signature and title of certifier

29a. Certifier

(Check only



HOUSE Touc

1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 00 47951

AUE

29d. Date signed (Month, Day, Year)

9-9-07

FREDERICIC, MD 21701.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 08 p^{M} 07 **JOHN** WESLEY 1:08 WILKINS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Southern Maryland Hospital Prince Georges Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 24, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 X M 2 □ F 87 200-05-0163 1919 PA Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10a State 10b. County 1 Yes 2 No Director MD Prince Georges Largo 10f. Zip Code 10g. Citizen of What Country? items 23a 500 N. Harry S. Truman Dr. Apt. 116 20774 U.S.A. **Examiner must** Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🕅 No Specify <u>^</u> 3 ☐ Widowed 4 TDivorced **Black** Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injuy or other traumatic event, the Medical Egge. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver City Sanitation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Wesley Wilkins, Sr. Hazel Idell Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cassandra Lee Freeman, Daughter 13100 Old Field Terrace, Laurel, MD 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Pleasant Valley 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 09/07/07 4 ☐ Donation 5 ☐ Other (Specify) Annandale, VA Memorial Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility AMES FUNERAL HOME, INC. 8914 Quarry Road, Manassas, VA 20110 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) nce of): Examiner athersilestre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) certificate be executed Exami that initiated events resulting in death) Last and Due to (or as a consequence of) burial-t P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) led by the a 1 □ Yes 2 □ No 9∏Unknown 9 ☐ Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral director. this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) al Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 0 . Name and addra of person who completed cause of death (Item 23a) (Type, Print) SE Sunte 310 Washington DC Zer 32 1328 Southern avenue m 31. Date filed (Month, E Year) State 2007 Registrar

Division or Vital Records, P.O. Box 68760, 24 hours after death completely within 2.

Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of sertifier

SEP 1 9 2007

mn



and manner stated.

address of person who completed cause of death (Item 23a) (Type, Print)

🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me, g881,07/11/198dbb Reg. No. Reg. No 2 Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day O7 **Physician** Burgess Zear 7 re /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balt: more University Maryland Medical Genter If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Director 217-82-8733 MAY 5,NY Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ural", or Items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director BALTIMORE DUNDALK MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 128 FLEMING DR USA Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2 🗷 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH LABORER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 FLEMING DR., DUNDALK, MD 21222 DOTTIE ALLEN-GARNES/AUNT 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 5712 O DONNELL State 1 Burial 2 □ Cremation 3 □ Removal from State 09/13/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21224 MT. CARMEL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. DX 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Jubarachnie **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit CERTIFICATIONA Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day 5 Other (specify) by the a 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t irector, page 2 s autopsy performed2 2 ☐ No 2 **2** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Medical Certification: To ours after death.

neral Director: After this filled in by the funeral d 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Makec street Baltimore MD 21201 82. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007

Registrar

0

07-07064 lantha Brooks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Brooks	- 1	State of Maryland / Department of Pertificate of Registrar	of Death	Reg. No. 2007 301
Physicia al Examin	ner	1. Decedent's Name (First, Middle,Last) IANTHA HELENA BROOKS	Mor Sep	e of Death th Day Year otember 11, 2007 14c. County of Death
		4a. Facility Name (if not institution, give street and number) 1406 Bellona Avenue	4b. City, Town, or Location of Death Lutherville	Baltimore County
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	ate of Birth (MM/DD/YYYYY) 9. Birthplace (State or Foreign. PT. 6, 1933 Country) MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local		10d. Inside City Limits
with the Maryland 18 23a or 28a-f show pe notified at once.	ector	MD BALTIMORE LUTHERVII 10e. Street and Number	I.I.E 10f, Zip Code	1 X Yes 2 No
the Mar	Dire	1406 BELLONA AVE.	21093	USA
ms 23; be not	eral	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	Vas Decedent of Hispanic Ongin? (Specify Y Yes, specify Cuban, Mexican, Puerto Rican,	es or No- 14. Race - American Indian, Black,
or item	Funeral	1 Yes 2 X No		
/2 hours after n "natural", c	2	3 Widowed 4 Divorced If Yes, Give Year 1 1 or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decede	Yes 2 X No specify: ent's Usual Occupation' (Give kind of work do	Specify: BLACK
ne. • than "nat ledical Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during	most of working life. DO NOT use retired)	HOSPITAL & PRIVATE DUTY
Hygiel tother		17. Father's Name (First, Middle, Last)	18.Mother's Name (First,	Middle, Maiden Surname)
Mental marked c event,	o Be	JAMES ALEXANDER	ELEANOR BUI	RTON oute Number, City or Town, State, Zip Code)
27 is n	F	DONALD BROOKS/HUSBAND 300		
Health item		20a. Method of Disposition 20b. Place of Disposition	osition (Name of cemetery, Date	
nt: If		Terroval from State		2007 WINDSOR MILL, MD
Department Important:		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility WESLE	Y CHAVIS, JR. FNRL. HM.
. 1 20		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	2007-09 EASTERN AVE	BALTIMORE, MD 21231 ratory arrest, shock, or heart Approximate Intervi
/sician		23a. Part I. Enter the disease, or complications that caused the death, both of enter failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive atheroscle)	15.45	Between Onset an
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.	11 - 11 - 11 - 11 - 11 - 11 - 11 - 11	
cian ar	ledical	X UNPENDED AMENDED #23a.PII.27.perME.g872	10/25/07 TT	
attending ph	sician/N	IF FEMALE: 236. If yes, outcome of pregnancy 236. If yes, outcome of pregnancy 1 Live birth 2 Present at time of death	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month Day Year
ed by the	by Phy	Part II. Other significant conditions contributing to death but not resulting in the	,···g 5 · · · · · ·	3e. Did tobacco use contribute to the cause of death?
in signed the deta	ed b	End-stage renal disease		1 Yes 2 No 3 Probably 4 V Unknown 4a. Was an 124b. Were autopsy findings available
cate has bee	Completed			4a. Was an autopsy performed? ✓ Yes 2 No 24b. Were autopsy findings availab prior to completion of cause of death? 1 ✓ Yes 2 No
certificate ector, page	Be	25. Was case referred to medical examiner?	26.Place of Death (Check only or	
er this	유	1 Yes 2 No Inpatient 2 ER/Outpatie		e 5 Residence 6 Other: Scene Describe how injury occurred
death. ctor: After y the funera	Certification:	1X Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	1 Yes 2 No	<u> </u>
pural or A ours after eral Dire filled in b	Sertific	3 Suicide 6 Could not be determined (Specify)		ocation (Street and Number or Rural Route Number, Cit r Town, State)
To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 2		
· s F 5	ğ	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) September 12, 2007
			Street, Baltimore, MD 21201	
Sta Registi	_		n Street, Baltimore, MD 21201	

State of Maryland Department of Health and Mental Hygiene 1- State Amend #12, perFH, #23a, perMD, G871, 9/20/07e Afficate of Death Reg. No. 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician Richard Bacon 10:37AM Larry SEPTEMBER 2007 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES HOSPITAL ALTIMORE If Under 1 Year 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Min. 1√ M 2□ F Months Davs Hours Yrs Director 55 217-58-2041 05 28 52 MD Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes X No Director MD Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or iury or other traumatic event, the Medical Examiner must be not or other traumatic event. 6008 Harrison 21228 U.S.A. Town Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married 1 Yes 2 YHo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nentary/Secondary (0-12) College (1-4or 5+) 12th grade nă <u>Campus Police</u> Univeristy of Md 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arnold E. Bacon ဂ္ Margaret Washington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 6008 Harriston Town Road, Catonsville, Md 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trainonce. Patricia Bacon-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Crownsville Vet 9/21/07 Crownsville, Md 21. Signifure of Funeral Service Licensee 22. Name and Address of Facility March F/H West humper 4300 Wabash Ave, Baltimore, Md 21215 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

G.I. Bleeding Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EMMORRHAGIO Physician : 30 HRS /Medical Due to (or as a consequence of): Examiner BIEDING VARICEAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of) Records, P.O. Box 68760, physician a the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed?

1 Yes 2 No Division or Vital Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25551 09, 14, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O S CATON AVE MADHURI KOYYA 900 BALTIMORE MD 21229 VENKATA 32. Régistrar's Signature 31. Date filed (Month, Day, Year) State 2007 2 1 1 Sant SEP 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ACON

			1 - For State Registrar	State of	Marylan	d / Depa <i>Cer</i>	artment of F	lealth a Death	and M	ental Hy	giene ,	2007	301	18
F	Physici	an	1. Decedent's Name (First, Middle, La	st)	Bleak	1 o v				2. Date of De Month Sept.	ath	200 ^{¥ear}	3. Time of De 11:44	
	/Medio Examin		4a. Facility Name (If not institution, giver Southern Maryla	e street and num	ber)	103	4b. City, Town, o		of Death		4c. Co	ounty of Death		12.11
	uneral rector		5. Social Security Number 6. S		7. Age (In yrs	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min	8. Date of Bird (Month, Da Oct. 5	h v. Yea <i>r</i>)	9. Birth	place (State or Fintry)	'oreign
the Maryland	r 28a-f show notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince 10e. Street and Number	George's		y, Town or Lo					10g. Citize		10d. Inside City L	
-0036 hours after death with the Maryland	nnt: If item 27 is marked other than "natural", or items 23a or 28a-f show iry or other traumatic event, the Medical Exa <u>miner must be notifiled at</u>	by Funeral	9211 Stuart Lane 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Moivorced	12. Was Deced Armed Fon 1 □ Yes If Yes, Give Year or Da	ces? 2 No		20735 Was Decedent of H f Yes, specify Cuba		gin? (Spe n, Puerto I	cify Yes or No Rican, etc.)	. 14	S.A. Race - Ameri Black, White		
Taryland 21215-0036 2 should be filed within 72 hours af 1 and Mental Hygiene.	er than "natura , the Medical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12th	ducation ade completed) College (1-	4or 5+)	(Give life. L	lent's Usual Occup kind of work done DO NOT use retired th Aide	during mos d)			16b. Kind of Business/Industry Health Care			ļ
Maryland d 2 should be file th and Mental Hy	arked othe atic event,	To Be C		Hartung	3	-1		1	Audre	(First, Middle,	a Rub	у		
and 2 shoealth and	n 27 is m ner traum		19a. Informant's Name/Relationship (2316	g Address <i>(Street</i> 6 Esperai	nza Di	r. Le	exingto	n Par	k, Mary	1and 20	653
altimore, mit. Pages 1 al partment of Hes	Important: If iter any injury or oth once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Signature of Funeral Say 9 lice	<i>(y)</i>	late	e_Crem	sition (Name of natory or other place atory . Name and Addre		Sept. 200)7	Clin	tion - City or T	aryland	
berm Depa	any i		23a Part1. Enter the disease, or com	7, M	0146	4	6633 01d	Alexa	andri	a Ferr	y Rd (ral Hom Clintor	ne, Inc. , MD 20 Approximate Interval Between	
/M Exa	sician and edical miner transit sthe prival-transit	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fany, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									Onset and Dea	ath	
U. BOX 6 the death certific	attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nth 2□Feta antattime of d	Ideath 3□	Ectopic pregnancy Other (specify)	/			23	d. Date of deliv	very Day Yea	ar
Hecords, P.	been signed by the should be detached	by	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the ur	nderlying cause giv	ren in Part I		23e. Did t		_	the cause of dea	
The law	ate has page 2	Completed								1□ Yes	rmed? 2 ☐ No	death?	opsy findings ava ompletion of caus 2 No	ailable se of
r Vital	iis certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 or	patient 2	ER/Outpatien	t 3 DOA Oth	or.		<i>(Check only o</i>		□Other (Spec	ify)	
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death.	or: After this certifica the funeral director, p		27. Mayor er of Death Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	n	h, Day Year)	28b. Time of Injury	M 1 □	yat k? Yes 2 ☐	No	28d. Describe				
DIVI:	ieral Director: filled in by the	Certification:	4 ☐ Homicide determined	buildir	ig, etc. (Specif	ý) 	eet, factory, office			City or To	vn, State)		ral Route Numbe	<i>r</i> ,
ne Hosp n 24 ho	To the Funeral C completely filled	edical			sis of examina		n occurred at the ti vestigation, in my o							
To th	To th	Me	29b. Signature and title of certifier				29c. Licens		20	٤	29d. Date	signed (Month	, Day, Year) と心フ	
			30. Name and address of person who	10 1328 4	of death (Iten	n 23a) (Type,	Print) me SE	Snik:	310 1	Deshins	ton	DC zor	32	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 0	2007	gistrar's Signa	iture	market .			V				

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifie

601

29c. License number

D0061882

Charle

29d. Date signed (Month, Day, Year)

and manner stated.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	of Maryland		artment of H <i>tificate of L</i>			giene 00	7 30120
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Lester I. Bevil					2. Date of De Month Septem	Day Y	(ear 7. 12 PM
	Examir		4a. Facility Neme (If not institution, give street and n Battimere Washington Medica 5. Social Security Number 6. Sex		ast birthday)	4b. City, Town, or Glen Burn If Under 1 Year		s. 8. Date of Bir	th S	undel County Birthplace (State or Foreign
	Funeral Director		223-22-9857 1図M 2□F Usual Residence of Decedent	84	Yrs.	Months Days	Hours Mi		ry, Year)	Country) Virginia
	Maryland	ctor	10a. State 10b. County Maryland Anne Arundel		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	th with the 23a or 28	al Director	10e. Street and Number 312 Glenwood Ave.			10f. Zip Code 21061			10g. Citizen of Wh United St	
980	d within 72 hours after death with the Maryland liene. r than "naturs!", or Itsms 23a or 28a-f show the Medical Examinar must be coulfied at	by Funeral	1 Never Married 2⊠ Married 1 ⊠ Yes	ecedent Ever in U.S Forces? s 2 □ No Give Dates: WW I	_ 1	Vas Decedent of Hi f Yes, specify Cuba I□Yes 21€ No	spanic Origin? (n, Mexican, Pue Specity:	(Specify Yes or No arto Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. Vhite
Maryland 21215-0036	within 72 hor ene. then "nstur he Medical I	Completed		(1-4or 5+)	(Give life. L	lent's Usual Occupa kind of work done of OO NOT use retired	furing most of w)	rorking	16b. Kind of Busi	ness/Industry
land 2	be filed ital Hyg od othe svent,	To Be Co	12 17. Father's Name (First, Middle, Last) Colon Lester Bevil		Crane	Operator			Coast Gu , Maiden Sumame)	
	d 2 should and 7 is mutanm		19a. Informant's Name/Relationship (Type, Print) Mary E. Bevil / Wife			-			er, City or Town, St	
Baltimore,	permit. Pages 1 en Depertment of Heeli Importent: If itsm 2 any injury or other once.		20a. Method of Disposition 1	n State	ar Hil	sition (Name of natory or other place) 1 Cemete: Name and Addres TKLEY-Ruc	ry	pt. 21, 2007 neral Ho	Brooklyn me, P.A. Burnie, M	Park, Maryland
	Physician /Medical Examiner		resulting in death)	t caused the death. each line. EU MON o (or as a consequence)	Do not ente	er the mode of dying	g, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
68760,	ificate be executed physicien and is the burial-transit	edicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	o (or as a conseque	ence of): ence of):	PDION APT	EZY.	Dis	EARE	
.O. Box	death certifi e attending d for use as	Physician/Med	in the cast 12 months?	outcome of pregnan b birth 2 ☐ Fetal of gnant at time of dea known	death 3	Ectopic pregnancy Other (specify)			23d. Date	
rds, P.	The law requires that the ite has been signed by this age 2 should be detache	þ	Part II. Other significant conditions contributing to	death but not resul	Iting in the ur	nderlying cause give	en in Part I.		obacco use contrib Yes 2 □ No 3	ute to the cause of death?
of Vital Records,		e Completed	25. Was case referred to medical				ag Dises of D	1 ☐ Yes	psy price design of the price o	ere autopsy findings available or to completion of cause of ath?] Yes 2 \(\square\) No
of Vil	Phys this raldi	To B	examiner? 1 Yes 2 No Hospital:		P/Outpatien		ar: 4 🗆 Nursing		dence 6 Other	
Division	I or Attanding Phatter death. Director; After this in by the funeral	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	e of Injury onth, Day Year) ce of Injury - At hon Iding, etc. (Specify)	Injury me, farm, stre		ମ Yes 2⊡No		Street and Number	or Rural Route Number,
	Hospital 4 hours Funeral ely filled	ledical Ce	29a. Certifier (Check only one)	he best of my know basis of examination	vledge, death ion and/or inv	occurred at the time vestigation, in my op	ne, date and pla binion, death oc	ce, and due to the curred at the time,	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and this of certifier	٧	ND	29c. License	TS149		29d. Date signed (-
_	10		CANTAISMO 31	use of death (Item	pikul	Print) driv	e 9	len Br	whie	362 18 2007 MD 20161
	Sta Registr		31. Date filed (Month, Day, War) 32 SEP 2 0 2007	ngistrar's Signati	y for	and I				

07-07207 Michael Babaka

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 30121 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day Year September 16, 2007 1503 hrs MICHAEL J. BABKA Medical Examiner Michael Joseph Babka 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) BALTIMORE CITY **Baltimore** University Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In vrs. last birthday) If Under 1 Year 5. Social Security Number 6 Sex **Funeral** Days Min Months Hours: OCT. 18, 1953 Director Country) MARYLAND 217-62-9959 53 1 X M 2 Usual Residence of Deceden 10d. Inside City Limits Ioc. City, Town or Location 10a State 10b. County Yes 2 XNo GLEN BURNIE ANNE ARUNDEL 28a-f show MARYLAND must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 21060 s 23a or 109 HAMMARLEE RD. 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes' or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes -10 WHITE Yes 2 X No specify: Give Yea Specify: Divorced Widowed Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. fant: filem 27 is marked other than "natural", or other traumatic event, the Medical Examiner. 2 16a. Decedent's Usual Occupation (Give kind of work done Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 WAREHOUSE 1 FORKLIFT OPERATOR 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JANET KRAUSE Be JOSEPH BABKA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) M 109 HAMMARLEE RD., GLEN BURNIE, MARYLAND 21060 CHERYL STEINER BABKA/COMPANION Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition timore. SEPT. 20 crematory or other place) Burial 2 X Cremation 3 Removal from State Department of Important: i METRO CREMATORY, 2007 CATONSVILLE, MARYLANI INC. 4 Donaţion 5 Other Specify Name and Address of Facility IRKLEY-RUDDICK 21 CRAIN HWY., 21. Signature of Funeral Service Licenses FUNERAL HOLS.E., GLEN HOME, P.A LEN BURNIE MD 21061 Approximate Interval 23a. Part I. Enter the disease, or compile a rons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Medical een Onset and failure. List only one cause on e ch line Death Myocardial infarct Immediate Cause (Final disease *xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X AMENDED #23a, PII, 27, perl #1, perME, g871, 9/26/07 10/26/07 X UNPENDED physician a The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ۾ Yes 2 ✔ No 3 Probably 4 Unknown End stage liver disease; asthma; Hepatitis C; chronic drug use Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? certificate has performed Yes 2 V No 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital To the Hospital or Attending Physician: Be Other; examiner? Hospital: 1 ✓ Inpatient 2 DOA Nursing Home 5 Residence 6 ER/Outpatient 3 After this 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within ? one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number Signature and title of certifie 29b g September 17, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. trar's Signature

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

31. Date filed (Month, Day, Year)

Physician /Medical Examiner

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Department of H
Important: If ite
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Physician

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Funeral

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28a-f show

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of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-1 shov other traumatic event, the <u>Medical Examiner must be notified at</u>

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Furneral Director: After this certificate has been signed by the attending physician and completely filled in by the furneral director, page 2 should be detached for use as the burial-transit more.

Division or Vital Records, P.O. Box 68760

Examine Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2☐ Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

29c. License number

D0058913

ALTIMORE, MARYLAND

29d. Date signed (Month, Day, Year)

2007.

BOULEVARD

SEPTEMBER

State

Registrar

31. Date filed (Month, Day, Year) 2 0 2007

Manusho

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 601 LOCH RAVEN

Bahl

State of Maryland / Department of Health and Mental Hygiene [] []]

- State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September 17, 2007 **Physician** Robert C. Burke 7:00 A.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1301 Cox Street Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F 213-46-3077 60 Yrs. Director 1947 Maryland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits in then "neturet", or iteme 23s or 28s-f show the Medical Examinar must be notified at Yes 2 No Maryland N/A Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1301 Cox Street 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No 3 ☐ Widowed 4 ☐ Divorced ģ Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Tow Truck Driver Elliott Towing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fi h and Mental H 7 ie marked ot Cecil Burke Anna Fisher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health at
Important: if item 27 ie
eny injury or other trau Anna Burke Mother 1301 Cox Street Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 9/20/2007 Fullerton, Maryland 4 □Donation 5 □ Other (Specify) 21. Signature of Faneral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or treat failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the ettending physician end hed for use as the burial-transit Due to (or as a consequence of) Box 68760. cai cate hes been signed by the ettending physic page 2 should be detached for use as the Physician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after death.
 Funeral Director: After to Certification: Injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and tyte of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAINSheed BOB 25 MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 200

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Physician
/Medical
Examiner

Funeral

Maryland 21215-0036

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SAID TO BE: Baltimore,

> or Attending Physician: The law requires that the death certificate be executed burial-transit for use as the ed by the a page 2 should be : After this certifice funeral director, [

Division of Vital Records, P.O. Box 68760,

Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10h County 10a State 28a-f ahov ?7 is marked other than "natural", or itams 23s or 28s-f shov traumatic event, its Medical Examinar must be notified at Director MD BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 302 CANTATA COURT, #403 21136 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental H **HACK** BETTY LOUIS 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. SHERI STERN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 09/19/2007 WORKMEN CIRCLE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Immediate Cause (Final STATIC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 25. Was case referred to medical Other: 4 2 No Certification: To 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of Injury Natural 5 Pending 1 Tes within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier amelli 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AIE, SUITE 2B, BALD MI 21209 AKHANI, 2835 8mITH 2. Registrar's Signature State

State of Maryland / Department of Health and Mental Hygien 2007 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 16 2007 1:00P BLATT 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE REISTERSTOWN FUTURE CARE- CHERRYWOOD If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 12/16/1933 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 1 □ M 2 X F 216-30-9237 MD 10d. Inside City Limits 1 Tyes 2 No 10g. Citizen of What Country? USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. WHITE Specify 16b. Kind of Business/Industry OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) ROSENSWEIG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 133 SUNNYDALE WAY, REISTERSTOWN, MD 20c. Location - City or Town, State BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Denknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? 2 100 26. Place of the ath | Check only one)

Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Anna V. Cartwright 10:00 AM eptember 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 🛛 F 87 Director 123-03-3057 March 25,1920 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unry or or other thaumatic event, the Medical Examiner must be notified at ury or or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 No Director Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1651 E. Belvedere Avenue 21239 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify. è 3 ☐ Widowed 4 X Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Counter Person Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank LaQuinta Anna Tracey ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shani M. Silvis (Granddghtr) 2728 Kildaire Drive, Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or of once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 09/18/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 9705 Belair Road, Nottingham, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Due to (or s a consequence of): Iday disease or condition resulting in death) /Medical Examiner apric plaque Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine physician and s the burial-trans Due to (or as a consequence of): Physician/Medical SE IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Dav 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Curunary gntery 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this P 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) within 24 hours after uses...
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the

or Attending Physician: The law requires that the death certificate be excepted Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

30. Name and address of person which mpilets cause of death (Item 23a) (Type, Print)

D0063163

29c. License number

29d. Date signed (Month, Day, Year)

Parkway Bultimore Maryland 21218 201 East Hospital, University Union Memorial 31. Date filed (Month, Day, Year) 32, Registrar's Signature

State Registrar

29b. Signature and title of certifier

M.0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KO Prince Mitchellville Georœs If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕽 F Director 89 June 21,1918 MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified at MD Mitchellville Prince Georges 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a or Examiner must be 3800 Lottsford Vista Road 20721 USA death v Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes No Black, White, etc within 72 hours after 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Je filed wit.

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' N (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Self Domestic 8th 17. Father's Name (First, Middle, Last) marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important; If Item 27 is marked oth any Injury or other traumatic event Be Robert Tolson Lillie Chapman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine Wilson 5999 Emerson St. 609 Bladensburg, MD 20710 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buria! 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Glenwood Cemetery 09/17/2007 Washington, DC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dunn&Sons 5635 Eads St. NE Washington DC and 1. Enter the disease, or complications that caused the death. hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** LOOKS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed physician and s the burial-trans Box 68760, Due to (or as a consequence of): Physician/Medical attending ph for use as th IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 mon Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached t o 9□Unknown ۵. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably as been signal 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed page certificate Division or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes Hospital: 2 140 1 | Inpatient Certification: To 2 ☐ ER/Outpatient 3□ DOA After this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) and title of cert 226

Registrar

31. Date filed (Month, Day, Year) 2 0 2007 SEP

Richard J. Feldman, M.D. 9500 Annapolis ROad SuiteA-4 Lanham, MD 20706 32. Restrar's Signature ERWA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			State of Maryland / Department /	artment of Health and M rtificate of Death	ental Hygier Reg. i	2007 30127
17			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	Physicia /Medic		Donna R. Connolly		September	r 18,2007 34A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Sinai Hospital	Baltimore If Under 1 Year If Under 24 Hrs.	8. Date of Birth	N/A
	Funeral		5. Social Security Number 216-74-0815 6. Sex 1	Months Days Hours Min.	(Month, Day, Yea	
	Director		216-74-0815 51		June 14,1	956 Maryland
	yland now at		10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits
	e Mar ia-fsl	cto	Maryland N/A Baltim	ore		XXYes 2□No
	or 28	Dire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	ath w	Funeral Director	4216 Edgehill Avenue	21211	oity Voc or No	USA 14. Race - American Indian,
	er de items ner m	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
0030	Irs aft	by F	1 □ Never Married 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1 □ Yes 2000No Specify:		Specify: White
ڄ ڄ	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	ted	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b	. Kind of Business/Industry
7	thin 7 e. an "n Medi	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of worki DO NOT use retired)		
7	ed wi	ပ္ပ	12 Acco	unting Department		State Highway
yland	be fill tal H d oth even	Be	17. Father's Name (First, Middle, Last)	Muriel M	(First, Middle, Maid	den Surname)
<u>Ş</u>	J Mer narke	မ	Donald Jacob Morgan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailin	ng Address (Street and Number or Rura		ity or Town State Zin Code)
Z Z	d2 sh th and 7 is n traun		(3)	6 Edgehill Avenue		
a)	1 an Heal tem 2		20a Method of Disposition 20b. Place of Dispo	sition (Name of		c. Location - City or Town, State
Ē	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentle Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at ance.		XXBurial 2 ICremation 3 IRemoval from State	matory or other place) Valley Mem. 9/22/	2007 Ti	lmonium, Maryland
galtil	mit. F		21 Signature Aperal Service Mans-e	2. Name and Address of Facility		
ă	Der Imp any		search aprile 3	urgee-Henss-Seitz 631 Falls Road, Ba	funeral H ltimore.	Home, Inc. 21211 Maryland
٠			23a. Part F. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on sach file.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Hemorrhade		2 Inset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence /)			
	LABITITIE	_	Sequentially list conditions, b. Due t. (or as 2 consequence of):			
۵.	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury			
7 0.	execunal and al-tra	Exar	that initiated events c Due to (or as a consequence of):			
98/60,	icate be executed physician and s the burial-transit	edical	d			
ĝ	tificat ig phy as th	ledi		18 to 18		
X R R	death certifica attending plants as the second	an/N	IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	☐Ectopic pregnancy		23d. Date of delivery Month Day Year
	e dear	sicie	in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 [Other (specify)		MOHIT Day real
J O	The law requires that the death certif te has been signed by the attending tage 2 should be detached for use a	Physician/M	Part II. Other significant/ponditions contributing to death/but not resulting in the u	inderlying cause given in Part I	23e. Did tobac	co use contribute to the cause of death?
ďŠ,	ires ti signe	by	Glipblestoma Multiforme	aariyiiig aaaaa girariiiir aarii	1 ☐ Yes	2 No 3 Probably 4 Unknown
ecords,	v requ	Completed	0 / 1000 000 000 000 000 000 000 000 000		24a. Was an	24b. Were autopsy findings available
Ř	The law cate has page 2 s	I di			autopsy perform ę g	prior to completion of cause of death?
Vital			25. Was case referred to medical	26 Place of Deat	1 Yes 2 1 1 1 Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	No 1 ☐ Yes 2 ☐ No
	yslclan: s certific director,	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Other:		e 6 □Other (Specify)
ō	ig Ph ter thi neral	ü	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 1 Injury	of 28c. Injury at Work?	28d. Describe how i	injury occurred
<u>0</u>	endir aath. or: Af he fui	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division or	or Att ter de ilrect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	pital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the caus	se(s) and manner as stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificy completely filled in by the funeral director,	Medical	(Check only one) Check only one) Check only			
	Fo the roughly the complex com	Me	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month, Day, Year)
)	> - 0		all mys D. well M.D.	D 0054911	(9-19-2007
,			30 Nameland address of person who complete Cause of death (Item 23a) (Type	Print)	1.11.	NE MD 21215
	10		30 Nameland address of person who complete ocause of death (Item 23a) (Type	reliverely the , , y	MITIMO	ME MD 21210
	Sta Regist		31. Date filed (Month, Day, Year) SEP 2 0 2007	carle		
	nogist					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene

Reg. No. 2007 For State Registrar Amend 24a, perverbal, 0871, 9/20/01/Centificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 16:05 M **Physician** September 18 2007 Muriel A. Davin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Upper Chesapeake Hospital Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03–17–1924 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min. Hours 1 □ M 2 ▼ F Yrs West Virginia 234-30-1047 83 Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene.

arked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21014 1406 E Bonnett Place U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2X No Specify: Completed by White 3 N Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Office Manager Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Lloyd L. Morton Genevieve Greathouse Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health Sem 27 I 317 Bevard Ct Aberdeen, MD 21001 Patricia Newing (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gar. 109-24, 2007 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd Bel Air, MD 21014 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute da Longe disease or condition resulting in death) /Medical Due to (or as a cons or ence of): 0 Examiner Ecquentially list conditione, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner that the death certificate be executed resulting in death) Last Due to (or as a consequence of): 68760, the as Box IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Year Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has autopsy performed? certificate 1□ Yes 2 No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation I hours after death. uneral Director: Af ely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) vo the ...
within 24 hours
the Funeral Dire. determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0056607

Sta

Registrar

Joseph Angezo
31. Date filed (Month, Day, Year)
SEP 2 0 2007

Suk # 205 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NO 602 S. ATWOOD Rd, BELADR, MD, 21014.

07-07095

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

erly Marie Dail	1- For State	State of Maryla		nent of l cate of i		Mental Hy	giene Reg. I	20	07	3013
Physician/	Decedent's Name (Fig. 1)	irst, Middle,Last)				2	2. Date of Death		3. Time of	
ical Examiner	Kimbe	erly Marie Dai	lev				Month Da September 1		1555	nrs
	4a. Facility Name (if not	t institution, give street and nu	mber)	4t	o. City, Town, or Lo	cation of Death	4c. County of Death			
	Good Samarita	ın Hospital			Baltimore					
Funeral	5. Social Security Numb	ber 6. Sex	7. Age (In yrs. last bi	irthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.		MM/DD/YYYY) 9. B Fore	eign	
Director	220-02-197	73 1 M 2XF	38	Yrs.	World Bays	TIOUIS INIII.	Apr. 10	,1969 °	Country Mar	yland
	Usual Residence of De								10d Insid	e City Limits
v any		o. County	10c. City, Tow							
shov shov	Maryland	N/A	Ba	altimo				1 X Yes 2 No		
the Maryland a or 28a-f sh ijfied at one Director	10e. Street and Number				10f. Zip Code		10g.	Citizen of What Co		
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show int: If item 27 is marked other than "natural", ar items 23a or 28a-f show or other transmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	4212 Sp	oringwood Aven	ue			21206			USA	
with ms 23 be no eral	11. Marital Status		cedent Ever in U.S.	13. Was	Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Arr White, etc				Black,	
or death with	1 Never Married	1 Yes	2XX No				about otoly		,	
after ner r		4 Divorced If Yes, Give Yes or Dates:						Specify:	white	3
5-0036 led within 72 hours after Hygiene. cother than "natural", the Medical Examiner Completed by	15. Decedent's Educa	ation (Specify only highest grad	de completed) 16a		's Usual Occupations of working life. I		- 1	6b. Kind of Busines	s/Industry	
6 172 h	Elementary/Seconda	ary (0-12) College (1	1–4 or 5+)		emaker			Own H	Iomo	
5-0036 Iled within 7 Hygiene. t other than the Medica	unknown			ПОШ			(5) - 1 AC - 10 - 14 -		one	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 perpartment of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	17. Father's Name (Fire				18		(First, Middle, Ma			
121 I be fil ental I nrked vent,		-		40t Mailian	Address (Occasi		Palmerin	er, City or Town, Sta	eto Zin Codo	\
Should and Mer 7 is man	•	Relationship (Type, Print)	1							,
MI 25 salth a alth a m 27 m 27 m 27	20a. Method of Disposi				tion (Name of cem			more, MD 20c. Location - City		te
or tr		Cremation 3 Removal fi		natory or oth		8				
Baltimore, permit. Pages I a Department of He Important: If ite injury or other tr	4 Donation 5	Other Specify:	Met		ematory	1	19/2007	Catonsvi	<u> </u>	
port	21. Signature of Funer	al Service Licensee		22. N Bu	ame and Address	of Facility SS-Seitz	Funeral	Home, In Marylan	ıC.	
o 5222	Her	Helespenly		36.	31 Falls	Road B	altimore	, Marylan	d 2121	1
Physician	23a. Part I. Enter the d	isease, or complications that one cause on each line.	aused the death. Do	not enter th	ne mode of dying, s	such as cardiac or	respiratory arres	t, snock, or neart	Betwee	mate Interval n Onset and
'Medical xaminer	Immediate Cause (Fin	A ambu uda								Death
Xammei	or condition resulting i		a consequence of):							
	Sequentially list condi	tions, b. Hanging	0							
9	if any, leading to imme cause. Enter Underlyi		a consequence of):			38.00				
Banger Framiner	(Disease or injury that events resulting in dea		a consequence of):	-						
n ransi de 100		d								
o, Se executed sician and ourial - transit	UNPENDED	AMENDED								
Box 68760, e death certificate be execut the attending physician and od for use as the burial - train	IF FEMALE:	23c. If yes	, outcome of pregnan	icy				23d. Date of deliv	very	
6876(certificate ading phy se as the b	23b. Was decedent pre	I LIVE		2	tal death 3	Ectopic pregna	incy	Month	Day	Year
or use	1 Yes 2 No	C of Halianum	nant at time of death	5 Ot	her (Specify)			ļ	,	
the death of the atternance of	Daniel Other disciplina	9 01181	to death but not resu	Itina in the I	indedicing cause a	iven in Part I	23e. Did tob	acco use contribute	to the cause	of death?
ed by Jetacl	Part II. Other signific	ant conditions contributing	to death but not resu	iting in the c	inderlying cause g	iven in rait i.		2 V No 3 F	_	
tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach							24a. Was ai			lings available
of Vital Records, g Physician: The law requires ther this certificate has been signeral director, page 2 should be							autops	y prior	to completion	
ecc he lav							perform 1 Yes 2		Yes	2 No
diffication 1 70		d to medical			26.Place	of Death (Check	only one)			
Vital hysiciam: this certification of director	examiner?	Hospital:	Inpatient 2 🗸 EF	R/Outpatien!	3 DOA	Other4 Nursir	ng Home 5 F	Residence 6 O	ther:	
Jof V	27 Manner of Death	28a Dat	te of Injury 28	8b. Time of I	Injury 28c. Injur	y at Work?		ow injury occurred		
ading	1 Natural			OUND:	1 Y	res 2 ✓ No	Subject hang	jed self		
ivision or Attend after death Director: I in by the	2 Accident	28e Pla	2, 2007 1 ace of Injury - At home	515 hrs e, farm, stre	et, factory, office b	uilding, etc.	28f. Location (S	treet and Number o	r Rural Route	Number, City
Division tal or Attendi	1 Natural 2 Accident 3 Suicide 4 Homicide	6 Could not be	Single Family		, ,,	•	or Town, St 4212 Springwo	ate) ood Avenue, Balti	more, MD	
		ertifying Physician: To the b			rred at the time do	ate and place, and				
he H in 24 he Fu	(Check only one)	ledical Examiner:On the basis	s of examination and	or investiga	ition, in my opinion	, death occurred	at the time, date a	and place, and due t	to the cause(s	3)
To the within 7 to the complet	(Check only one) 2 M 29b. Signature and tit	and manner	stated.		29c. Licens			29d. Date signed		
12	29b. Signature and tit	1 of all			O.C.I			September 13		/
	Mhrs	Branell Mi	18		0.0.1	IVI. L.		Coptember 10	, <u>2</u> 001	
'n		ss of person who completed ca) =	04004			
7	30. Name and addres Melissa Brass	sell, MD Assistant M	ledical Examine	r 111 F	Penn Street, B	Baltimore, MD	21201			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Hilda E. Ernst 2:10a September 19,07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2431 Island Branch Rd. White Hall Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months 1 □ M 2 😾 F Director 220-03-4181 86 11-12-1920 Balto. _MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at White Hall MD Harford 1 ☐ Yes 23 No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? ŏ 2431 Island Branch Rd. 21161 USA 23a permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a amy Injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Yes 2 No Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White þ 3√2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Goetze Production 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William F. Rode Elizabeth Frei ပ 19a. Informant's Name/Relationship (Type. Print)daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2431 Island Branch Rd.White Hall, MD 21161 Patricia Garcia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/11/2007|Baltimore,Maryland Oaklawn 4 Donation 5 Other (Specify) 22 Name and Address of Facility Joseph N. Zannino Jr. FH 21. Signatur Funeral Service Licensee 263 S. Conkling St.Baltimore, MD 21224 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Part I. Enter the disease shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Fin disease or condition resulting in death) **Physician** onelyear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician are the burial-t Division or Vital Records, P.O. Box 68760 Physician/Medical attending for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 ☐ Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an as S certificate ha performe 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:

completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certific 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Chec 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one re and title of certifier 29b. Signat 29d. Date signed (Month, Day, Year) September 20, 2007

State Registrar

DHMH 17 Rev 1/2001

SE SE

31. Date filed (Month, Day Year)

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rood # 208,

320

Registrar's Signature

loward Charlie I	i	For State Certificate of Dea	ath	Reg.	No. 200	7 3013
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Howard Charlie Eanes		2. Date of Death Month September	ay Year	3. Time of Death 1616 hrs
r ^{e +}			, Town, or Location of Death	. September	4c. County of Death	
			ntingtown	D. D. G. of District	Calvert	Abelese (Chalese
Funeral Director		579 48 8507 XX 2 F 73 Yrs. Moi	nder 1 Year If Under 24Hrs. this Days Hours Min.	8. Date of Birth(Sept 2	1 1022 Foreig	thplace (State or gn puntry) Virginia
any was a second		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
* ,	5	Maryland Wicomico Salisbury				1 Yes 2 XX No
ith the Maryland 23a or 28a-f sho notified at once	Director		Zip Code		. Citizen of What Cou United Sta	
vith the s 23a o			1801 dent of Hispanic Origin? (Sp.			ican Indian, Black,
death w	Funeral		ecify Cuban, Mexican, Puerto		White, etc.	
safter r'al", o	by F	or Dates:	2 XX No specify:		Specify: Whit	
2 hour	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	al Occupation (Give kind of w working life. DO NOT use retir		or a grand mark	· · ·
5-0036 led within 72 hours a tygiene other than "natura the Medical Examin	Completed	12 Lithograp			DOD	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland reath and Montal Hygiene fresh and Montal Hygiene tem 27 is marked other than "natur'al", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Be Co	17. Father's Name (First, Middle, Last) Thomas J. Eanes	18.Mother's Name Carri	(First, Middle, Ma e McCart	,	
ID 21; should'b and Mon 7 is marl			ess (Street and Number or R liet Owl Lane,			e, Zip.Code)
e, MD l and 2 sho Heath and item 27 is			Name of cemetery, Sept		20c. Location - City o	r Town, State
		Fort Lincoln		18,2007	Brentwood	, MD
Baltimore permit. Pages J. Department of I Important: If injuty or other			nd Address of Facility CC			
		23a: Part I. Enter the disease, or complications that caused the death. Do not enter the more	dria Ferry Ro)735 Approximate Interval
Physician المراجعة		failure, List only one cause on each line.	ac or dying, saon as cardiac or			Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a CUITING WOUND OF ARRIVE Due to (or as a consequence of):		710		· · · · · · · · · · · · · · · · · · ·
	. <u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		223 14	-	
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated				24
executed an and al - transit	Exa	events resulting in death) Last Due to (or as a consequence or): d				
50, te be executed ysician and burial - transit	edical	UNPENDED AMENDED				
3760 ificate ig phys		IF FEMALE: 23b. Was decedent pregnant in the 2 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea	ath 3 Ectopic pregna	ncy	23d. Date of delive Month	ry Day Year
ox 68 th certi	sician/N	past 12 months? 4 Pregnant at time of death 5 Other (\$			4.	
, P.O. Box 6876 res that the death certificat signed by the attending phy be detached for use as the	Phys	Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
P.C es that iigned b		Hypertensive atherosclerotic cardiovascular disease; Atrial fibrilla		1 Yes	2 No 3 Pro	obabły 4 🗹 Unknown
cords, aw requii has been s	Completed by			24a. Was ar autopsy	y prior to	utopsy findings available completion of cause of
tal Reco cian: The law certificate has ector, page 2 s	duo			perform 1 Yes 2		res 2 No
tal F cian: ` certific ector, 1	Be C	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3	26.Place of Death (Check			
of Vi ing Physi After this uneral dir	ဥ	1 Yes 2 No	DOA Nursir 28c. Injury at Work?	28d. Describe ho	tesidence 6 Oth	er: Scene
On C cuding sath. or: Af the fun	ıtion	1 Natural 5 Pending FOUND: FOUND: 1600 bre	1 Yes 2 No	Subject cut s	elf	
Division of Vital Rec pital or Attending Physician: The I ours after death. eral Director: After this certificate I filled in by the funeral director, page	Certification:	3 ✓ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fac	tory, office building, etc.		reet and Number or F ate) ane, Huntingtown	Rural Route Number, City
D lospital I hours uneral		29a. Certifier				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	(Check only one) 2 Medical Examiner: On the basis of my knowledge, death occurred an and manner stated.	my opinion, death occurred a	at the time, date a	nd place, and due to	the cause(s)
F S F S	M	29b Signature and title of Certifier	29c. License number O.C.M.E.		29d. Date signed (M September 17,	
		30. Name and address of person who completed cause of death (Item 23a)	O.O.IVI.E.		Captember 17,	200/
8			Penn Street, Baltimor	e, MD 21201		
	tate	31. Date filed (Month, Day, Year) SEP 2 0 2007 32. Registrar's Signature				
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			For State A #6 m	State of	Maryland / Dep	ertificate of	Health a			30133
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The same of the sa	hysicia /Medic	_		RDELILA	FITZGERALD	45 Cit. Town	!	Septemb	oer 16 2007	2:pm M
	xamin	er	4a. Facility Name (If not institution, 1121 RAMBLEWOOD			4b. City, Town, o		or Death	Ac. County of Dea	
	ineral		5. Social Security Number		Age (In yrs. last birthday		If Under 2	24 Hrs. 8. Date of Bir Min. (Month, Da	th 9. Bin y, Year)	thplace (State or Foreign ountry)
10 m	ector		216-30-1145 Usual Residence of Decedent		75 Yrs.			JAN 7	1932 MAR	YLAND
aryland	ehow dat	_	10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
the M	28a-f	Directo	MARYLAND N A		BALT	IMORE 10f. Zip Code			10g. Citizen of What C	1
th with	23a or		1121 Ramblew	ood Rd. Ap	t B.	212	239		U.S.A	
er dea	teme territ	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	. Was Decedent of If Yes, specify Cub	Hispanic Origon, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)	14. Race - Am Black, Wh	
5-0036 72 hours after death with the Maryland	Examilia	by	1 ☐ Never Married 2 ☐ Marri 3 🎇 Widowed 4 ☐ Divorced	ed 1 □Yes 🐉 If Yes, Give Year or Date		1 ☐ Yes 2 🛱 No	Specify:		Specify: BL	ACK
21215-0036 ad within 72 hours af rgiene.	natur	Completed	15. Decedent (Specify only highes		(Giv	edent's Usual Occu e kind of work done	during most	of working	16b. Kind of Business	/Industry
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ind 2 be filed	d othe	BeC	17. Father's Name (First, Middle, I	Last)			7	r's Name (First, Middle	1	
Maryland of 2 should be file tith and Mental Hy	Item 27 is marked other then "natural", or Iteme 23a or 28a-f show other traumatic event, the Medical Exacilizational buricilitied at	ပ္	CHARLES HOSE 19a. Informant's Name/Relationsh	oin (Tyne Print)	19h Mai	ling Address (Stree		QUELINA MUE	RRAY er, City or Town, State,	Zin Code)
and 2 s	27 Is or trau		Jacqueline J.						The second second	
		711	20a. Method of Disposition 12 Burial 2 □ Cremation		ate cemetery, cr	ematory or other pla	ace)		Balto., M. 20c. Location - City o	
Baltimore, permit. Pages 1 a Department of Hea	rtant: njury o		4 □ Donation 5 □ Other (State of Funeral Service I	oecify)	GARRISON			09-24-07	OWINGS MIL	
Depa Depa	eny l		Dashasa	Bur		206 W. NO			ABROWN COM	100111
	1 1		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death. Do not e	THE PARTY OF THE P			rrest,	Approximate Interval Between
	sician edical		Immediate Cause (Final disease or condition resulting in death)	-a. Me	tastat	1 C C	trei	noma		Onset and Death
	miner				as a consequence of	- Bro	DNE	noma		
D D	ii.	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequence of):					
60, v	sicien and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence of):					
8760,	hysicier the buri			d						
death certificate	aing ph	Physician/Medical	IF FEMALE:	230 H vae outco	ome of pregnancy					
Box	a attending p	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birt 4 ☐ Pregnar	h 2 Fetal death 3 nt at time of death 5	☐Ectopic pregnand	су		23d. Date of de Month	Day Year
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ds, l	5 6	þ	Part II. Other significant condition	ns contributing to dea	th but not resulting in the	underlying cause g	iven in Part I.		tobacco use contribute Yes 2□No 3□F	robably 4 Unknown
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of Vita	tis certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ➡ No	Hospital:	4		ther	of Death (Check only		
	After this funeral di	-	27. Manner of Death	28a. Date of	Datient 2 ER/Outpati Injury 28b. Time Day Year) Injury	of 28c. Inju	4 🗆 190		idence 6 Other (Sp how injury occurred	ecity)
Vision Attending	tor: After th the funeral	catlo	1	gation		M 1	Yes 2 🔲		/0	
Division all or Attend	Direc in by	Certification:	4 Homicide determ	ined 286. Place o	f Injury - At home, farm, s g, etc. <i>(Specify)</i>	street, factory, office			(Street and Number or F own, State)	Rural Houte Number,
To the Hospital within 24 hours a	To the Funeral Direc completely filled in by	edical C	(Check only 2 Medical	Examiner: On the bas	est of my knowledge da is of examination and/or					
To the within 2	o the	Med	one) 29b. Signature and title of certifier	and manne	r stated.	29c. Licen	se number	2 - 0	29d. Date signed (Mor	nth, Day, Year)
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	V		7 1	who completed cause	of death (terr 23a) (Typ		ub.	21216		V
	Sta Registr		31. Date filed (Month, Day, Year)	2007	gistrar's Signature	asi				

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 0203 AM 15,200 IE eptember /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A JOHUS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6-29-1918 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1□_M 2□ F SOUTH CAROLINA 228-10-9437 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show must be notified at 1 TYes 2 □ No Director N/A BALTIMORE MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 2 USA 21217 2118 WALBROOK AVE. Funeral r than "natural", or items the Medical Examiner mu Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or her any Injury or other traumation. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify: BLACK þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16h, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MERCHANT MARINE LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELLA PRINGLE ROBERT FELDER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2118 WALBROOK AVE. BALTIMORE, MARYLAND 21217 SHON FELDER (GRANDSON) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Djeposition 1 X Burial 2 Cremation ☐Removal from State KING MEMORIAL PARK 9-22-2007 BALTIMORE, MARYLAND 4 □ Donation 5 ☐ Other (Specify) eral Service License JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Cause (Final Zdays **Physician** r condition in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Division or Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ĮQ. in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ∐ Yes 2 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tes 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifie September 15, 2007 30. Name and address of person who con pleted cause of death (Item 23a) (Type, Print) Avenue Bultimore, MD 21224 Neal Eastern 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2007 SEP 2 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend state of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Year Baby Boy Gray 0203 September 2, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HODKINS Hospital Baltimore If Under 1 Year If Under 24 Hrs. Hours Min. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**∑**M 2□F **Director** none Maryland 28, 2007 Aug Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notifled at Director 1√Yes 2□No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3208 Ravenwood Avenue 21213 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ black Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none none 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Ilisha Gray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 600 N. Wolfe Street Baltimore, MD Johns Hopkins Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 21. Signature of Fanoral Service Licence Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Necrotizina Enterocolitis 6 hours /Medical Due to (or as a consequence of): **Examiner** Perforation Bowel 6 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transit Frematurit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a, Was an autopsy performed? Yes 2 No 2 No 1□ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this s after death.

I Director: After this id in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Fo the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelly Ecker Do. 31. Date filed (Month, Day, Year) North Wolfe Street, Nelson 2-133, Baltimore, Maryland 21287 600 ingistrar's Signature State SEP 2 0 2007 Registrar

			For State Registrar	State of Mary	land /		tment of F <i>ficate of</i> a			giene Reg. No.		30136
	Physici	an	1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	. Day	Year	3. Time of Death
	/Medic	al	Ann C. Ginsberg 4a. Facility Name (If not institution, given	e street and number)		4	lb. City, Town, o	r Location of Dea	Deptem		17 200 7 County of Deat	
	LAGIIIII	Ç.	PENINSULA REGIONA		ENTE		SALUS B If Under 1 Year				VICEMO	
,	Funeral Director		214-16-3262	6ex 7. Age (In	yrs. last b		Months Days	If Under 24 Hrs Hours Min		av, Year)	Co	hplace (State or Foreign untry) yland
975	rland ow		Usual Residence of Decedent 10a. State 10b. County			wn or Loca	tion					10d. Inside City Limits
0-1	e Marylan ta-f show tified at	ctor	Maryland Harfor	i	Abin	igdon						1 □Yes 2 X No
900-31-0975	death with the Maryland oms 23a or 28a-f show r must be notified at	Funeral Director	10e. Street and Number 314 Barclay Ct				10f. Zip Code 2100	q		U.S.	izen of What Co	untry?
B	death ems 23 r musi	nera	11. Marital Status	12. Was Decedent Ever Armed Forces? 1 Yes 2 No	in U.S.	13. Wa			Specify Yes or Norto Rican, etc.)		14. Race - Ame Black, White	
Ginsberg 1215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygients. The important; if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 □ Never Married 2 □ Married 3 🛣 Widowed 4 □ Divorced	1 ☐ Yes 2 🔏 No If Yes, Give Year or Dates:			Yes 2 No	Specify:	110 1 110 111 111 111 111 111 111 111 1		Specify:	White
2/7	72 ho "natur dical I	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16	a. Deceder	nt's Usual Occup nd of work done	ation during most of we d)	orking	16b. Ki	ind of Business/	Industry
Ginsber	iene. jene. the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2	N		Anesthe			Vet	terans H	lospital
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Ann	hould to Men marked marked matic	ပ္	Unknown 19a. Informant's Name/Relationship	Type Print)	10	9h Mailing	Address (Street	Ida Bal	Rural Route Numb	ner City o	or Town State	Zin Code)
	und 2 s alth an 27 is		Stewart Ginsberg				•		111s, MD			ip Gode)
Baltimore	ges 1 art of He		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐		Ob. Place ceme	of Disposit tery, crema	ion (Name of tory or other plac	ce)	Date	20c. Lo	ocation - City or	Town, State
<u> </u>	nit. Pa artmen ortant: Injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	1 ,	Wood1		Cemetery Name and Addre					Maryland
ă	permii Depar Impor any ir		Buan a. W	ille				D.C	nimunek nail Rd 1			e of Bel Air 21014
	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		death. Do	303	the mode of dyin		ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
7	/Medical Examiner			Due to (or as a co	onsequenc	,	1					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events	b. Due to (or as a co								
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89			IF FEMALE:	23c. If ves, outcome of p	roonanay							
C B C	. 0 00	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal dea		ctopic pregnanc Other <i>(specify)</i>	ý			23d. Date of del Month	ivery Day Year
ر 1	quires that n signed build be deta	þ	Part II. Other significant conditions Cerebra Vascula		, ,	in the und	erlying cause giv	en in Part I.				o the cause of death?
Division or Vital Records D O	ysician: The law requires is certificate has been somether that has been some continuations.	Completed							24a. Was auto perf 1∏ Yes		prior to death?	utopsy findings available completion of cause of
it a	cian: ertifica sctor, p	BeC	25. Was case referred to medical examiner?				l au		eath (Check only		7 10100	-
ż	Physi r this c ral dire	ျ	1 Yes 2 No 27. Manner of Death	Hospital: 1 Hipatient 28a. Date of Injury		Outpatient o. Time of	3 DOA Oth	4 Li Nursing	Home 5 ☐ Res			cify)
	ath. rr: Afte	ation	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear)	Injury	28c. Injui Woi M 1 □	k? Yes 2∐No		now mya	ny coodinou	
Divie	il or Atte after de I Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		At home, Specify)	farm, stree	t, factory, office		28f. Location City or To	(Street ar own, State	nd Number or Ri e)	ural Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical C	29a. Certifier (Check only one) 2 dical Exa	hysician: To the best of m miner: On the basis of exa and manner stated	amination	lge, death o and/or inve	occurred at the ti stigation, in my	me, date and pla opinion, death oc	ce, and due to the curred at the time	e cause(s , date an	s) and manner as id place, and due	s stated. e to the cause(s)
	To th within To th	Me	29b. Signature and title of entitler				29c. Licens	se number	3	29d. Da	ate signed (Mont	th, Day, Year)
	10		30. Name and address of person who		(Item 23a	a) (Type, Pr	int) Penma	1. 00	- / IN	101.	dist	Sakiroum
I	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's	Signature	S.	1 STING	uia ne	71444	COTIC	مر رحمد	my/
	Registi		SEP 2 0 2	007 Ser 2000	R	1004	ELS.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. SHATEN WATEN HOS DEPARTMENT OF SEATING HEAT WE AND HEAT HYGIEN & 007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09 16 2007 10:00 am N. Gross Aurelia 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Gilchrist Nursing Home Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 16 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days 1 M 2 TF 183-16-7873 Yrs. 91 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No NA MD 10e. Street and Number Bet Iou 3128 Bent Iou James Place 10f. Zip Code 10g. Citizen of What Country? 21207 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Black X□ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
12th grade College (1-4or 5+) Domestic Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Jane Hall William H. Neal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 21207 Betton James Place, Baltimore, Md Thomas Colbert-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Arbutus, Md 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 9/21/2007 21. Sign uneral Service Licer 22. Name and Address of Facility
March F/H West 12 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AITURMS ENDSTAGE leas Due to (or as a consequence of): Sequentially list conditions, if any leading to list audit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Tes 29€ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death
Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical **Examiner** Records, P.O. Aurelia or Vital Division To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After

Examine burial-trar Physician/Medical Completed by Be ဥ Certification: Medical

Physician

/Medical

Examiner

Funeral

Director

"naturat", or items 23a or 28a-f show diral Examiner must be notified at

Maryland 21215-0036

Baltimore,

12 should be filed w h and Mental Hygier r is marked other th

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra

Director

Funeral

Completed

3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Towsartown Blid Balto MD 21204 022M.

State Registrar

State of Maryland / Department of Health and Mental Hygiene 2007 30138 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Harper 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner actimore Social Security Number and Medic If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 10, 56 1951 MD AUG. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show iral", or items 23a or 28a-f shov Examiner must be notified at 1 XYes 2 No Director BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4022 HAYWARD AVE 21215 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. within 72 hours after 1 X Never Married 2 ☐ Married **BLACK** "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) LABORER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT HARPER DOROTHY STEVENSON 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLADYS HARPER/SISTER 247 ST. MATTHEWS ST., BALTIMORE, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5712°° DONNELLStar. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/14/2007 BALTIMORE, MD 21224 MT. CARMEL 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIORE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) de formation de la consequence of: Physician nknown /Medical Examiner unknew Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown been signed by t should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ. 1 | Yes 2 | No 3 | Probably 4 | Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral (27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 ☐ Pending investigation Natural spital or Attendil ours atter death. neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral (Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rea 32. Régistrar's Signature 31. Date filed Month, Day, Year) State 0 Registrar

Villiam	Ahston	Hawkins	
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/illiam Ahston I		kins State	e of Maryland /	Departme	nt of Health ar te of Death			200	7 3013
Physicia		Registrar 1. Decedent's Name (First, Middle,La	ast)				2. Date of Deat		3. Time of Death
Medical Exami	ner	-	lston	Hawki			Month Septembe		0800 hrs
		4a. Facility Name (if not institution, g 1921 E. 30th St.	ive street and number)		4b. City, Town, o	or Location of D	eath	4c. County of Deat	n
Funeral			Sex 7. Age	(In yrs. last birth		ear If Under 2	4Hrs. 8. Date of Birt	th (MM/DD/YYYY) 9. Bit	thplace (State or
Director		213-82-4742 1	X M 2 F	38	Yrs. Months Da	ys Hours	Min. 8–10–	1969 Forei	gn puntry) Md.
any.		10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits
*	ř	Md. NA		Balt	imore		10.1		1 X Yes 2 No
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number			10f. Zip Code		. 10	0g. Citizen of What Cou	ntry?
th the 23a or		5611 Daywalt A			2120			USA	
ath wi	Funeral	11. Marital Status 1 X Never Married 2 Marrie	12. Was Decedent if Armed Forces?	_	 Was Decedent of F If Yes, specify Cuba 			- 14. Race - Amer White, etc.	ican Indian, Black,
safter death with the Maryland rial", or items 23a or 28a-f sho tiner must be notified at once.	by Fu	3 Widowed 4 Divorce	ed If Yes, Give Year or Dates	X No	1 Yes 2X N				lack
hours		15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade com College (1-4 or 5	di	ecedent's Usual Occup uring most-of working li			16b. Kind of Business	Industry
5-0036 led within 72 tygiene, other than	Completed	12th grade	NA	,	Disabled			NA	
5-0036 led within 72 hours after Hygiene other than "natural", the Medical Examiner		17. Father's Name (First, Middle, La				18.Mother's N	lame (First, Middle, M	Maiden Surname)	
2121 uld be fill Mental F marked c event, j	Be	William	McCut				trice	Alsto	
, MD 21215-0036 and 2 should be filed within 72 hours eatth and Mointal Hygiene ten 27 is marked other than "natur raymmatic event, the Medical Exam	မ	19a. Informant's Name/Relationship Jackie Lewis	(Type, Print) Brother		6611 Daywal			nber, City or Town, State	
ages I and 2 shount of Health and It: If item 27 is rother traumatic		20a. Method of Disposition		20b. Place of	Disposition (Name of o		Date	20c. Location - City o	
Pages 1 nent of 1 ant: If or other		1 X Burial 2 Cremation 3			y or other place) Carmel Cem.		9-22-07	Dundalk,	Md.
Baltimore, permit. Pages I at Department of Hee Important: If ite injury or other tr		21. Signature of Funeral Service Lice			22. Name and Addre	ss of Facility	March F.	H. East	
™ 5 5 1 1		Dlady	wo and		1			H. East imore, Md.	21202
Physician /Medical		23a. Part I. Enter the disease, or cor failure. List only one cause on		the death. Do not	enter the mode of dyin	g, such as card	iac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Alcohol and Due to (or as a conse		toxication	7 4	,		Death
		Sequentially list conditions,	b	4001100 01).		2 P. C.			
	iner	If any, leading to immediate	Due to (or as a conse	quence of):		2			1
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
), be executed ician and urial - transit	I		d						
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Box 68760, e death certificate by the attending physical for use as the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	e or pregnancy	Fetal death 3	Ectopic pr	regnancy	23d. Date of deliver Month	y Day Year
Sox 6 leath ce attend for use	sicis	1 Yes 2 No 9 Unknow	4 Pregnant at t	time of death 5	Other (Specify)			Î	
that the denet by the detached 1	Phy	Part II. Other significant conditions		but not resulting	in the underlying cause	given in Part I	, 23e. Did to	bbacco use contribute to	the cause of death?
rds, P.O.	d by						1 Yes	s 2 No 3 Pro	bably 4 🗸 Unknown
rds requi	Completed						24a. Was autop		utopsy findings available completion of cause of
tal Reco	E O							rmed? death?	
Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred to medical examiner?			26.Pla	ce of Death (Ch	neck only one)		
FVIt Physic al dire	2	1 🗸 Yes 2 No	Hospital: 1 Inpatier		patient 3 DOA			Residence 6 Othe	er: Scene
n of ding Ph	ü	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day,Ye	ear)	1	jury at Work? Yes 2 X No		how injury occurred	
isior Attender death	icati	2 Accident Investiga	ation FIIC 9/14/		7:45 am			Street and Number or R	ural Route Number, City
Division of Vital Records, P.O. Box 6876(the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phys inpletely filled in by the funeral director, page 2 should be detached for use as the b	ertification:	3 Suicide 6 X Could no determine	ot be	other- re		<u>.</u>		state) t 30th St. Ba	
Hosp 24 hor Fune rtely fi	O	29a. Certifier 1 Certifying Phys	ician: To the best of my				, and due to the caus	e(s) and manner as sta	ted.
Divisio To the Hospital or Atterwishin 24 hours after deat To the Funeral Director	Medical	one) 2 Medical Examin	er:On the basis of exam and manner stated.	nination and/or in			red at the time, date		
	Σ	29b. Signature and title of certifier	TA			nse number		29d. Date signed (Me September 14, 2	
		30. Name and address of person wh	O completed course of the	agth (Itom 03a)		/.IVI.E.		Deptember 14,	2001
manager (OU INSIDE SUG SOCIESS OF DEISON WIT	o conneted cause of de	50 U U EU / 38 1					

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

32 Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Zabiullah Ali, M.D. Assistant Medical Examiner

State 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of Maryis Registrar		ertificate of L		Reg. No		30140			
Ver	Physicia	_		ell-			Date of Death Month Da		3. Time of Death 11.03A M			
	/Medic Examin	al -	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	plenster 40	. County of Death	7 031			
	LAGIIIII		Harborside Health Care			imore	P to the Birth	NA	(0)			
	Funeral Director		5. Social Security Number 213-28-9483 Usual Residence of Decedent 6. Sex 1 □ M 2 7. Age (In y 85	yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Year 3–1–1922		place (State or Foreign ntry) Md.			
	/land	ŀ		. City, Town or L					10d. Inside City Limits			
:	Ba-f sh tiffied	ctor	Md. NA	Balt	imore		1		1 X Yes 2 □ No			
:	death with the Maryland ims 23a or 28a-f show r must be notified at	Funeral Director	10e. Street and Number 3809 Delverne Rd.		10f. Zip Code 212			10g. Citizen of What Country? USA				
9500	be illed within 72 hours after death with the Marylar Hydjene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	n U.S. 13.	B. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Specify in, Mexican, Puerto Rica Specify:	Yes or No- an, etc.)	14. Race - Ameri Black, White Specify:				
င်္ဂ	72 hou 'natura dical E		15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occupa we kind of work done	ation during most of working	16b.	Kind of Business/li	ndustry			
7	within iene. than " he Mec	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		. Do Nor use retired Homemaker	"		Own Home				
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	21 22 22 22		19a. Informant's Name/Relationship (Type. Print)			and Number or Rural Rue Rd., Balt						
a) .	s 1 and f Health Item 27 other t			b. Place of Disr	position (Name of rematory or other place	Date		Location - City or				
Baitimor	Pages ment of ant: If It lury or o		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	King Me	-	9-20-0	07 Ra	andallsto	wn, Md.			
3alt	permit. Departi Importi any inj		21. Signature of Funeral Service Licensee		22. Name and Addres	Mai	rch F.H.		1000			
			23a. Part1. Enter the disease, or complications that caused the	death. Do not e	1101 E. No enter the mode of dyin	orth Ave., I	Baltimore espiratory arrest,	e, Ma. 2	Approximate Interval Between Onset and Death			
- 20	Physician	Immediate Cause (Final disease or condition)										
	/Medical		resulting in death) a. Due to (or as a con	nsequence on:	1	1 0			1-2 hous			
	Examiner	7.	Securifically list conditions if any leading to immediate b. Due to (or as a con	sequence of):	enal e	failure	A					
	uted d ansit	Examiner	Su hally list on dili ns if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Pari	pheral	Vaxule	u de	LOSE				
Ď,	tificate be executed g physician and as the burial-transit	Еха	resulting in death) Last Due to (or as a con	nsequence of):								
09/89	cate b physic the bu	edical	d									
	aath certifi attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf provided in the pinth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	3 □Ectopic pregnancy 5 □ Other <i>(specify)</i> _	,		23d. Date of deli Month	very Day Year			
rds, P	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not	t resulting in the	underlying cause giv	en in Part I.	23e. Did tobacce 1 ☐ Yes		the cause of death? obably 4 V Unknown			
II Records,	sician: The law rer certificate has bee irector, page 2 shor	Completed					24a. Was an autopsy performed? 1□ Yes 2 XII	prior to e	topsy findings available completion of cause of 2 No			
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ŏ	g Physer this eral di	7: To	27. Manner of Death 28a. Date of Injury	2 ER/Outpati 28b. Time ar) Injury	of 28c. Injur		d. Describe how in		спу)			
Ö	ending ath. or: Aft he fun	atio	2 Accident Investigation			Yes 2 □ No						
Division or	al or Atta after de Directa d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury building, etc. (Si	At home, farm, : pecify)	street, factory, office	28f	Location (Street City or Town, St		ıral Route Number,			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my one) Certifying Physician: To the best of my one and manner stated.	y knowledge, de imination and/or	eath occurred at the ti r investigation, in my	me, date and place, and opinion, death occurred	d due to the cause at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)			
	To th vithir comp	Me	29b. Signature and title of certifier Dues Impe	naen	29c. Licens	30661	29d. 1	Plewley	19th 2007			
	5		30. Name and address of person who completed cause of death 500 / 20 Ch Latern /	(Item 23a) FTyp	pe, Print) Ball	inole.	Hd-	2123	9.			
4,30	St: Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 0 2007 32. Registrar's 3	Signature	Sparke							

AMENDED BY COUNTY UNState of Maryland / Department of Health and Mental Hygiere 0 7 30 4								
			1 - For State Registrar		cate of Death	Reg. N	_0010	0141
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Sister Thereson	Marie Hogi	ret	2. Date of Death Month D	2007	3. Time of Death
	Examir	er	4a. Facility Name (If not institution, give s 1525 Marriotts	reet and number)	Narrio Hsuile	4	c. County of Death Howard	1
	Funeral Director	_	5. Social Security Number 4 1 6. Sex		Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Yea. Feb +4, 193	9. Birthplac Country	e (State or Foreign
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or items 23a or 28a-f show any lipity or other traumatic evant. It is Mudical Exertified an Once.	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	11 11		10d	Inside City Limits
		Director	MD Howa		of Zip Code	10g. C	itizen of What Country	
		erai D	1525 Marriott.		21104	positu Vos as No	USA 14. Race - American	Indian
		To Be Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tyes 2000 No	Decedent of Hispanic Origin? (Sps., specify Cuban, Mexican, Puerto res 2 No Specify:	Rican, etc.)	Black, White, etc	
			15. Decedent's Educ (Specify only highest grade	ation 16a. Decedent's (Give kind	s Usual Occupation of work done during most of work	ting 16b.	Kind of Business/Indus	stry
			Elementary/Secondary (0-12)	College (1-4or 5+) Register	ed Durse/Ch	appain 1	Health (are
			17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary E. McWilliams					
			Francis Joseph 19a. Informant's Name/Relationship (Ty)	e, Print) 19b. Mailing Ad	Idress (Street and Number or Run	1 000		
			Sister Hnna Illar 20a. Method of Disposition	20b. Place of Disposition	(Name of y or other place)	Date 20c.	Location - City or Town	n, State
			New Cathedral Cem. 9/21/2007 Baltimore, Maryland					
			21. Signature of Pymeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228					
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and mpp of completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or page 2.	Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between					pproximate
			Immediate Cause (Final disease or condition resulting in death) a. Rou Tulve Note on The Control of the Contro				21	norths
			Saxual finally list conditions if any, leading to immediate by Due to (or as a consequence of):					
			cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
,09								
687			d	7.5			1	
.O. Box			IF FEMALE: 23b. Was decedent pregnant in the past 12 montbs? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		opic pregnancy er (specify)		23d. Date of delivery Month Da	ay Year
Δ.		d by Ph	Part II. Other significant conditions con	ributing to death but not resulting in the underf	ring cause given in Part I.		use contribute to the	
Division of Vital Records,		Medical Certification; To Be Completed	14Y20X14 24a. Was an autopsy prior to oc				24b. Were autops	y findings available detion of cause of
			1+ VpG+CDS/VD 25. Was case referred to medical			performed?	death?	L No
			25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					•
			27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28d. Describe how inj	ury occurred		
			2 Accident 3 Suicide 4 Homicide investigation Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Nu City or Town, State)			Rou <i>te Number</i> ,	
			29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
			29b. Signature and title of certifier 29c. License number 00055332 29d. Date signed (Month, Day, Year) BM694024C(0-A) SOptember 19th 2002					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Anne L. Mantello Min High. Redways (Moret #620)						Bultim	re, MD à	11201
		State Registrar SEP 2 0 2007 32. Registrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 17, 2007 Day Physician Dolores Ann Harris 3:30A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2108 Lansdowne Road Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
Oct 24,1935 Maryland 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F 216-32-1581 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heathh and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c, City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Director Md. Baltimore Baltimore 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code be of 2108 Lansdowne Road 21227 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural", or items dical Examiner mo Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify è Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th Sales Ladv Clothing Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William A. Ozazewski Elnor Dembeck 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. Harris, Sr. 2108 Lansdowne Rd. Baltimore, Md. 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Sother (Section Combinent Gardens of Faith 9-21-2007Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) carcinoma year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any 1 cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last iding physician and se as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2. ☐ No Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed2 ves 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 The Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Iniurv 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) September 16, 2007

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

NEwtawst

Baltimore MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richey Hospice

838

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Hoke, 12 200 Lloyd Gregory /Medical 4a. Facility Name (If not institution, give street and number) Ballimore 4c. County of Death 4b. City, Town, or Location of Death Examiner Extended Care Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb24, 1929 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. **X**XM 2□ F Pennsylvania Director 162-22-8446 Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show be notified at 10d. Inside City Limits 10a. State 10b. County Arundel Glen Burnie Md. 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. ral", or items 23a (Examiner must b 609 Tanyard Cove Road 21060 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★1 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner 1 Never Married XX Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2☐No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tile Setter Flooring 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lloyd Gregory Hoke, Sr. Lula Gemmill ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1708 Dundalk Avenue Baltimore, Md. Dora Wickline-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Bayview Crematory 9-14-2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service License Whent 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CANCER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) attending physician for use as the buria Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached fo ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Mariner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 0

Cornell William Johnson 07-07216 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2007 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Year September 17, 2007 0448 hrs Medical Examiner Johnson Cornell William 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Johns Hopkins Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Maryland Months Days Hours Director 08/26/1984 1 X M 2 Yrs 23 218-06-2600 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 X Yes 2 No 28a-f show **Baltimore** death with the Maryland Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number U.S.A. 21218 718 Cator Avenue 23a Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 1 X Never Married 2 Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Marrie 2 X No Yes after Specify: Black If Yes, Give Yea Yes 2 X No specify: Widowed Divorced "natural" à Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours: Department of Health and Mental Hygiere Important: If item 27 is marked other than "natura injury or other traumatic event, the Medical Examin 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) None None 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lelisca Johnson Reginald Little 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21218 718 Cator Avenue, <u> Lelisca Johnson / Mother</u> 20b. Place of Disposition (Name of cemetery, Date 20c Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 crematory or other place) Cremation 3 Removal from State Donation 5 Other Spec Mt Landsdowne Maryland Signature of Funeral Service Lice 4611 Park Hgts. Ave., Baltimore, Maryland 21215 Approximate Interval at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complications **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Gunshot wound of neck Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last y the attending physician and hed for use as the burial - transit Physician/Medical UNPENDED AMENDED the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes No this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? DOA Nursing Home 5 Other Inpatient 2 V ER/Outpatient 3 Residence 6 1 V Yes No 28a. Date of Injury (Month, Day Year) Sep 17, 2007 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Subject shot 0411 hrs Natural 1 Yes 2 V No 5 Pending To the Funeral Director: completely filled in by the f Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 900 Block of Belgian Avenue, Baltimore, MD (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. OCME September 17, 2007 30. Name and address of person who completed dayse of death (Item 23a) 3 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. Assistant Medical Examiner 32 Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar SEP 2

OŘIGINAL

30145 State of Maryland / Department of Health and Mental Hygien ? 17 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** atrice Johnson 20 00 M September 14 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITUL Baltimore City HOPKINS Johns If Under 1 Year II Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 08 05 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year) 53 1 ☐ M 2 🖫 F MD Director 54 217-66-6220 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Directo Anne Arundel Jessup MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20974 U.S.A. 8310 Autum Way Apt 2B Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give 1X Never Married 2 ☐ Married ŏ 1 ☐ Yes X☐ No Specify: Specify: Black چ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bon Secours Hospital 12th grade 4yrs Temp Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I int: If Item 27 is marked of Anna Davage Edward Johnson Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gabrielle A. Johnson-Daughter 8310 Autum Way Apt 2B, Jessup, Md 20974 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Department of Important: If eny injury or once. Druid Ridge 9/21/07 Pikesville, Md 21. Signature of Funeral Service Licensee March F/H West 21215 4300 Wabash Ave, Baltimore, Md al Approximate Interval Between Onset and Death 2 Pint. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute renal failure **Physician** /Medical Due to (or as a consequence of): Examiner 3 montus Acute myeloid leukenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No After the funeral of 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 15, 2007 I bironke Oduyebo, Medica Doctor Res-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ibironice Oduyeb. The Johns Hupking Hospital, 600 North Wolfe Street, Baltimore, Maryland 21237 32. Registrar's Signature Gara State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 687607

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fh 9871 9-20-07 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 30146 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>007</u> **Physician** Jane Kuhn Sept. 18 7:56 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Gilchrist Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F Yrs. 219-16-7542 88 Director Feb. 4 1919 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2 □ No Director MD Baltimore Lutherville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1414 Front Ave. 21093 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: white þ Specify. 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Batchelor Nan Myers ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) **Valerie**Pardew/daughter 1005 Rayville Rd., Parkton, MD 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 17 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 9/22/07 Timonium, MD Dulaney Valley Memorial Gardens 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral Inc. Michael iágle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** acule /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 □ Yes 2 🔀 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? certificate 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 5 0 5 0 1 Ce 1 Yes 2 No After this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐Pending investigation 1 Matural 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

Kι

Day, Year

0 2007

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31. Date filed (Month, D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

2. Registrar's Signature

29c. License number

D25205

Charles St. Balto and

29d. Date signed (Month, Day, Year)

		for State		State of	i Marylar	-	artment of F rtificate of		d Mental			7 201		
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must	Funeral	8700 Ri	dge Koa		dent Ever in U	J.S. 13.	21042		(Specify Yes	Uni	ted Sta	ates nerican Indian,		
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2	Be C	17. Father's Name (First, Middle, Last) Francis Joseph Lentz Walburga Nece								,				
Ē	မ	Francis Joseph Lentz Walburga Necesson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town,								n or Town, State	. Zip Code)			
Lia		Michael 1				1								
othe		20a. Method of Dis			20b. F	Place of Dispo	Pine Gro	ce) C	Date	20c.	Location - City of	or Town, State		
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any injury or other traumatic event, the Monoce.		21. Signatur of Fu	uneral chice	License	1 00 0	22	2. Name and Addre	ss of FacilityAn	brose	Funera	al Home.	. Inc.		
E 5		The	22. Name and Address of Facility Ambrose Funeral Home, Inc 1328 Sulphur Spring Rd Arbutus, Maryland 21227 23a. Part1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
o		23a. Part1. Enter t shock, or hea	the disease, or art failure. List	complications that er only one cause on er	aused the deat ach line.	th. Do not ent	er the mode of dyir	ng, such as card	liac or respirat	ory arrest,		Approximate Interval Between		
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Carl Eugene Locklear, Jr. September 16, 2007	Locklear,	j	State of Maryland / Department of Health and Mental 1- For State Certificate of Death 1. Decedent's Name (First, Middle,Last)		3. No. 200	7 30 L 3. Time of Death
Section Contract		er	Carl Eugene Locklear, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of D	Month September	Day Year 16, 2007	0940 hrs
The state of the s			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	8.40 a.C. 1.75	Fore	ign
201 Dundalk Ave. Baltimore MD 21222	Pages 1 and 2 should be filed within 72 hours after death with the Maryli ment of Health and Menal Hygiene from I filem 27 is marifed other than "naturial", or items 23a or 28a-for other traumatic event, the Medical Examiner must be notified at on	To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location 10f. Zip Code 10f	(Specify Yes or No- uerto Rican, etc.) d of work done e retired) Name (First, Middle, M R. Lewi er or Rural Route Num erive Bal Date -22-07	USA 14. Race - Ame White, etc. SpecifyWhi 16b. Kind of Business Automo taiden Surname) S ber, City or Town, Sta timore, 20c. Eocation - City of Baltimor	1 Yes 2 X No untry? rican Indian, Black, t e. r/Industry tive te, Zip Code) MD 21222 or Town, State e, MD
State State Part II. Contribute Part II. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. September 18, 2007 Part II. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. September 18, 2007 Part II. Part II. Part II. Part III. Pa	hysician /Medical xaminer	Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardialize. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	diac or respiratory arre		Approximate Interval Between Onset and
25. Was case referred to medical examiner? 1	te be ysicia buria		23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic p 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	1. 23e. Did to	Month	Day Year to the cause of death?
1 Yes 2 No No Natural 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Injury		Completed		24a. Was a autop perfor	an 24b. Were sy prior to death?	autopsy findings available completion of cause of
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Visitars's Signature	Attending Physic death.	의	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 1 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation Other4 1 1 Ves 2 No Other4 1 28a. Date of Injury Sep 15, 2007 0100 hrs 1 Yes 2 No	Nursing Home 5 28d. Describe t Subject shows 28f. Location (\$28f. Location (\$2	now injury occurred t self Street and Number or	
29b. Signature and title of certifier 29c. License number O.C.M.E. September 18, 2007 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Signature	o the Hospital or vithin 24 hours aftu o the Funeral Di ompletely filled in		Suicide 4 Homicide Could not be determined (Specify) Townhouse / Rowhouse 29a. Certifier (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	or Town, S 1214 South M e, and due to the caus	tate) arlyn Avenue, Esse e(s) and manner as st	ex , MD
State 31. Date filed (Month, Day, Year) 32. Mogistrar's Signature	F 3 F 8		29b. Signature and title of certifier 29c. License number O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)	4004		-
			31. Date filed (Month, Day, Year) 32. Tegistrar's Signature	1201		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Reg. N2 U U ont's Name (First, Middle, Last 2. Date of Death **Physician** /Medical not institution, give Name /// Atreet and number or Location of Death unty of Deat Examiner If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Days Min. Hours 1000 2∏ F Yrs Director 10c. City, Town or Lo 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, it e Modical Examinar must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Ses 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etg. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working fig. DO NOT use retired) 15. Decedent's Education 16b. King of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If tiem 27 is marked other than "rany injury or other traumatic awant secure." Elementary/Secondary (0-12) College (1-4or 5+) WISIK s Name (First, Middle, s Name (First, Middle, Be or Rural Route Number 19b. Mailing Address (Strpe and Num ce of Disposition (Name of 20a. Method of Date 1 Burial 2 Der mation 3 □Removal from 4 Donation 5 🗆 Other (Specify) of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Physician ena stage renat diseuse disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent oregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the i 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown à cate has been signed , page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown CHIF 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 25 No certificate 5 CPSIS

25. Was case referred to medical 1 Yes 1 ☐ Yes 2 ☐ No director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the t 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (11 M balaium Huith 00055157

Registrar

DHMH 17 Rev 1/2001

2

St.

breene

Baltimore

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 H H Co N BALANSON ID N

31. Date filed (Month, Day, Year)

SEP 2 0 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month Gary E. Miller 9 16 2007 5:55p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Joseph Richy Hospice Baltimore NΔ 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1**X**M 2□ F 217-56-7143 56 8-14-1951 Md. Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5462 Bucknell Road 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operator Tractor Trailer 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Miller Joseph Lois Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nickia L. Trafton Daughter 1820 N. Wolfe Street, Baltimore, Md. 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 9-21-07 Randallstown, Md. King Mem. Pk. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 Warren 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastalic disease or condition resulting in death) Dancreatic unknown Due to (or as a consequence of): Sequentially list conditions Directo (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 9☐Unknown Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Innatient 2 ER/Outpatient 3 DOA 6 Dother (Specify) +050102 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner

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To the Funeral Director Af

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Physician

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Funeral

Director

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Pages 1 and 2 should be filed within 72 ho nent of Health and Mental Hygiene. unt: If item 27 is marked other than "natur rry or other traumatic event, the Medical.

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Baltimore, Maryland 21215-0036

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Funeral

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Examiner Physician/Medical

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No

examiner? 1 Yes 2 No	edica
27. Manper of Death	

5 ☐ Pending investigation 6 ☐ Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

Medical

3 ☐ Suicide

4 Homicide

🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospice 838 NEutan St Baltimore MD 2120

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

07-07211

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2007 30151 State of Maryland / Department of Health and Mental Hygiene **Deion Morris** 1. For State Certificate of Death Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1700 hrs September 16, 2007 **Medical Examiner** DEION LEE MORRIS c. County of Death 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Baltimore** Johns Hopkins Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours Months Country) Director 1984 1 X M 2 F 15. MAR. 214-21-9904 23 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 No BALTTMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1624 E. Oliver St with the USA 3418 ERDMAN 21213 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Yes 0. BLACK Specify: Yes 2 X No specify: Divorce If Yes Give Year item 27 is marked other than "natural", à 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) within 72 21215-0036 CONSTRUCTION be filed within ental Hygiene. LABORER 9TH 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PHYLLIS V. CREEN Tyrcease Morris æ ges I and 2 should be f t of Health and Mental WILLIAM LEE MORRIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) B MD 21213 BALTIMORE, 1624 E. OLIVER ST., PHYLLIS V. ROUZER 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1903 HOLLINS FERRY RD. 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Pages 1 09/25/2007 LANSDOWNE, MD 21227 tment c MT. ZION Other Specify Donation 5 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. 21. Signature of Funeral Service Licenses 2007-09 EASTERN AVE., BALTIMORE, MD 21231 Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea **Physician** failure. List only one cause on each line Death /Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical UNPENDED X AMENDED 18, perFH, g872 attending physician or use as the burial Records, P.O. Box 68760, 23d. Date of delivery If yes, outcome of pregnancy IF FEMALE: Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atter 1 Yes 2 No 9 Unknown Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 V No 3 Probably 4 Unknown \$ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? this certificate has I director, page 2 sl death? 1 1 ✓ Yes 2 Yes 26 Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Division of Vital Be examiner? Hospital: Other; Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other 1 ✔ Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Sep 16, 2007 28b. Time of Injury After 27. Manner of Death Subject shot Certification: s after deam. 1625 hrs Natural Yes 2 V No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) 3400 Belair Road, Baltimore, MD determined (Specify) Street 4 V Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 17, 2007 O.C.M.E. who completed cause of death (Item 23a) 30. Name and address of person 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Patricia Aronica-Pollak MD 32 Registrar's Signature 31. Date filed (Month, Day, Year, State SEP Registrar

		1	For State Registrar	State of M	•	epartment of He Certificate of D		Reg.	/	30152
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			Usual Residence of Decedent 10a. State 10b. Count		10c. City, Town o	r Location		001. 0,	1337	10d. Inside City Limits
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	or 28e	Funeral Director	10e. Street and Number FUTU	JRECARE - BO	STON ST.	10f. Zip Code			. Citizen of What Co	ountry?
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		•	For State Registrar	, , , , , , , ,	Certificate of L	Death	Reg	2001	30153	
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	he Ma 28a-f s	Director	MD NA	Ве	altimore		100	g. Citizen of What Cou		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	al Dir	740 Poplar Grove Stree	t Apt	4-N 10f. Zip Code 21	216	100		riuy?	
	ter dea items ner m	Funeral	11. Marital Status 1 ■ Was Deceden Armed Forces 1 ■ Yes 2 ■ Warried	?	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spec an, Mexican, Puerto P	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White		
036	ours aff rat", or Exami	by	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:		Specify: B.	lack	
Maryland 21215-0036	n 72 ho "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)		6a. Decedent's Usual Occup: (Give kind of work done of life. DO NOT use retired	ation during most of working f)	7 B	6b.Kind of Business/Ir altimore	City	
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Division or Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of in building,	njury - At home, etc. (Specify)	, farm, street, factory, office	2	8f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,	
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	3		30 Name and address of person who completed cause of	Leativ (nem 23a	a) (Type, Print)	SHOW	Hal of	HALT	MONX	
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Reg. No. 2007 State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician ALICE SEPTEMBER(6, 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CENTA 3 ALTIMONS RANDA/STOWN NORTHWEST If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Hours 1 □ M X □ F 212-44-0834 61 22 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21207 3615 Forest Garden Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. X ☐ Never Married 2 ☐ Married Specify: Black Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired,

Labor Relations

Specialist lementary/Secondary (0-12) MD Classified Employee Assoc. College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Nelson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3615 Forest Garden Ave, Baltimore, Md 21207 Tracie Wyman-Daughter altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)

Signatur | □ Ineral Service Licensee 9/24/07 Arbutus, Md Arbutus Memorial 21/ Signatur March F/H West 4300 Wabash Ave, Baltimore, Md 21215 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final dise se or condition resulting in death) CEREBRO VASEULAS Physician Alute /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 5. as case referred to medical examiner? 2 No Hospital or Attending Physician: 26. Place of Death (Check only one) Be 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**11** H0 11 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier MORTHWEST HOSPITAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CONTANTO nexory (me) DREADO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

07-07149 Kevin Nielson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 30155

	1- For State Registrar		Certificate of	Death		Reg	. No.				
Physician/ Medical Examine	Decedent's Name (First, Middle)	_{e,Last)} ielsen				2. Date of Death Month I September		3. Time of Death 1143 hrs			
	4a. Facility Name (if not institution Bayview Hospital	n, give street and number)		4b. City, Town, or Lo Baltimore	cation of Death		4c. County of De				
Funeral Director	5. Social Security Number	6. Sex 7. Age (In	yrs. last birthday) 48 Yrs	If Under 1 Year Months Days	Birthplace (State or reign New York						
	218-76-5990 Usual Residence of Decedent 10a, State 10b, County		. City, Town or Locat			Sept9	, 1909	10d. Inside City Limits			
nd show any	M.J. II.om	ford	Edgew			1 Yes 2 X No					
the Maryland or 28a-f show fified at once	10e. Street and Number 3072 Deepwa	ter Way		10f. Zip Code 2104	.0	10g. Citizen of What Country? U.S.A.					
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once effect hy Funeral Director		12. Was Decedent Eve arried Armed Forces?	. If Y	as Decedent of Hispa es, specify Cuban, I	anic Origin? (Sp.			nerican Indian, Black,			
safter de rall, or i	3 Widowed 4 Div	orced If Yes, Give Year or Dates:	1	Yes 2 X No		in dian "T	Specify: W				
5-0036 ed within 72 hours tygiene. other than "natur the Medical Exan	15. Decedent's Education (Spe Elementary/Secondary (0-12) 9 t h		during m	nt's Usual Occupationost of working life. E	OO NOT use retir	ed) . : · · · ·	Baltimo News Pa	re Sun			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" injury or other traumatic event, the Medical Examina To Be Completed by		 , Last) glas Nielser		18		(First, Middle, M					
MD 212 d 2 should be th and Ment n 27 is mark umatic eve		ship (Type, Print)	. 19b. Mailin	g Address (Street a				tate, Zip Code) d . 21040			
ore, M ges I and 2 of Health If item 2 ther traur	20a, Method of Disposition 1 Burial 2 X Cremation	n 3 Removal from State	20b. Place of Dispos	ther place)		Date 0 = 2 0 0 7	20c. Location - City	re, Maryland			
Baltimore, Permit. Pages I a Department of He Important: If it injury or other t	4 Donation 5 Other S 21. Signature of Funeral Service	Licensee	22.1	Name and Address of	of Facility acz	orowsk	i Funer	al Home,PA			
Physician	23a. Part I. Enter the disease, or failure. List only one cause	a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
/Medical_ xaminer	Immediate Cause (Final disease or condition resulting in death)	I lama andurala	ence of):		3		0	Death			
1	Sequentially list conditions, if any, leading to immediate	b. Lung Cancer Due to (or as a consequence)	ence of):								
ted Insit	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	ence of):								
760, totale be executed physician and the burial - transi	UNPENDED	AMENDED									
	IF FEMALE: 23b. Was decedent pregnant in to past 12 months? 1 Yes 2 No 9 Ur	the 23c. If yes, outcome of Live birth 4 Pregnant at time 19 Unknown	2 F	etal death 3 ther (Specify)	Ectopic pregna	ncy	23d. Date of del Month	ivery Day Year			
ires that the de signed by the Ibe detached the by the by the by the by the by the by the by by by	Part II. Other significant condi		it not resulting in the	underlying cause gi	ven in Part I.			e to the cause of death? Probably 4 Unknown			
w requires the speed signer is been signer should be depended by						24a. Was a	n 24b. Wer	e autopsy findings available to completion of cause of			
ian: The law requires the law requires certificate has been signed to a property.				26 Place	of Death (Check	1 Yes 2		h? Yes 2 No			
f Vital F Physician: ar this certifical director,	1 Yes 2 No	Hospital: 1 Inpatient	2 Z ER/Outpatien	nt 3 DOA	Other Nursin	g Home 5		Other:			
Affe		28a. Date of Injury (Month, Day,Year) estigation		1 Y	at Work?	28d. Describe h	ow injury occurred				
Division o spital or Attending hours after death. Inneral Director: Afty filled in by the fune contribution:	3 Suicide 6 Cou	28e. Place of Injury uld not be ermined (Specify)	- At home, farm, stre	eet, factory, office bu	uilding, etc.	28f. Location (S or Town, St		r Rural Route Number, City			
To the Hospital within 24 hours a To the Funeral completely filled	= 29a. Certifying F	Physician: To the best of my ki aminer:On the basis of examin and manner stated.	nowledge, death occu ation and/or investiga	urred at the time, dat ation, in my opinion,	e and place, and death occurred a	due to the cause at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)			
E W F S	29b. Signature and title of certif		1/	29c. License O.C.N			29d. Date signed September 1	(Month, Day, Year) 5, 2007			
	30. Name and address of perso Carol Allan, MD As	n who completed cause of deal		Street, Baltimo	ore, MD 2120	1	<u></u>				
Stat Registra	e 31. Date filed (Month, Day, Year			- 40							
DHMH 17 Rev 1/200		OCME	ORIGINA	AL.	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier@ 30156 1 - For State Registrar Certificate of Death Reg. No 2 Date of Death 's Name (First, Middle, Last, 3. Time of Death **Physician** 0 Xºª /Medical County of Death Town. or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. last birthday) 6. Sex (State or Foreign **Funeral** Days 1 ☐ M 2 € Director Usual Residence of Decedent with the Maryland 10h. Count 10d. Inside City Limits or items 23a or 28a-f ehov or other treumatic event, the Medical Examiner must be notified a 1 Yes 2 No Director reet and Numb 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death Funeral . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White/letg. 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 þ 3 ₩idowed 4 Divorced "natural", Be Completed 16a. Dec • nt's Usual Occupation (Gire find of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. Item 27 is marked other then Specificary (0-12) lege (1-4or 5+) Ci Father Name (First Middle La Mother's Name (First, Middle, Maiden Sumame) 2 19b. Mailing Address Street isposition Department of H Importent: If its any injury or of Cre ation urial 3 Remov I from State 4 □Don on 5 □ ther (Specify) permit. 21. Signature of Foneral Service Licenses 22. Name and Address Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician (4468 /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the Hospitel or Attending Physicien: The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No detached 9 Unknown 9 Hinknown been signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 XNo 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Natural Injury 5 Pending investigation death. 1 🗌 Yes 2 Accident Director: 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after 4 - Homicide To the Funeral Less Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapper stated. 29a. Certifier Medical (Check only one) within 29b. Signature and title License number 29d. Date signed (Month, Day, Year) 7007 Who co inpleted cause of death (Item 23a) (Type, Print) 30. Name and add tin Edelman 22 South Greene St. Baltimore, MD Mar 31. Date filed (Month, Day, Year) SEP 2 0 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2007

07-07250 Jeffrey Lee Peters

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate o	of Death	Reg. N	<u>.</u> 201	
nysicia Exami	an/	1. Decedent's Name (First, Middle,Last) Jeffrey Lee Peters			2. Date of Death Month Da September 1	Year 7, 2007	3. Time of Death 1830 hrs
		4a. Facility Name (if not institution, give street 406 Bayshore Drive	The second secon	4b. City, Town, or Location of De Ocean City		4c. County of Death Worcester	
neral		Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24	Hrs. 8. Date of Birth (M	3. Time of Death 1830 hrs 183	
ector		214-40-8551 1XM	2_F 65 Yr		09-15-19		• •
ر بر الم الم	um * 8	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loca	ation			10d. Inside City Limits
28a-f show at	5	Maryland Wicomico	Ocean Cit	У	_		1 X Yes 2 No
23a or 28a-f sho	Directo	10e Street and Number 406 Bayshore Drive		10f. Zip Code 21842		Citizen of What Cour	ntry?
1s 23a	ral	11. Marital Status	. Was Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - Ameri	
or iten	Fune	Never Married 2 Married 1 3 Widowed 4 X Divorced If Y	Yes 2 X No	Yes, specify Cuban, Mexican, Pu Yes 2X No specify:	erto Rican, etc.)		
ural"	è.	15. Decedent's Education (Specify only h	ighest grade completed) 16a. Decede	ent's Usual Occupation (Give kind		1	
ın "na cal Ex	leted		College (1-4 or 5+)	most of working life. DO NOT use			A Salata Sal
Medi	Compl	12+	Elec	trical Maint. V	Vorker		
Mental Hygiene marked other than ' c event, the Medical	Φ	Harold E. Peters,	a general and the first profession of the first section of the second section of	Domi	m also 1 . 3 . 3 .	A And Shill a common	man and standing of the standi
mark ic ever	To B	19a. Informant's Name/Relationship (Type,	Print) 19b. Mailir			City or Town, State	, Zip Code)
n 27 is	and to	Michael Peters (S		and the second second			Town State
nt of Healt t: If item other trau		The second of th	crematory or c	ofher place)			
Departme Importan injury or		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	22.	Name and Address of Facility	Schimunek Fu	neral Hom	e of BelAir
ician	140	23a, Part I. Enter the disease, or complicate	ions that caused the death. Do not enter	the mode of dying, such as čardi	ac or respiratory arrest,	shock, or heart	Approximate Interval
dical		failure. List only one cause on each l	Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19b. Mailing Address of Exception Route Number or Rural Route Number, City or Town, State, Zip Code 19b. Address of Disposition (Name of cemetery, Date of Disposition (Name of cemetery, Date of Disposition (Name of Cemeter), Date of Disposition (Name of Cemetery, Date of Disposi				
niner		or condition resulting in death) Due	to (or as a consequence of):	au . ja		3-1-1	41.14 J
	_	Sequentially list conditions, b,	As (as as a series suppose of):				
	nine	if any, leading to immediate Due cause. Enter Underlying Cause (Disease or injury that initiated c.	to (or as a consequence or).	and the second			*
nsit	Exar	events resulting in death) Last Due	to (or as a consequence of):				
an and ra	edical	UNPENDED a.	MENDED				
physic he bur	Med		23c. If yes, outcome of pregnancy				ý
the attending I	ian/	235. Was decedent pregnant in the past 12 months?		Fetal death 3Ectopic pr Other (Specify)	egnancy	Month	Day Year
he atte d for u	Physician	A No. 1 TO Man O Literature	Unknown	Striet (Opechy)			
etache	by Pt	Part II. Other significant conditions con	ntributing to death but not resulting in the	e underlying cause given in Part I			
has been signed by 2 should be detach			· · · · · · · · · · · · · · · · · · ·		24a. Was an		
as bee	Completed	growth #5		· •	autopsy performe	prior to	
cate h	mo.				1 ✓ Yes 2		es 2 No
this certificate I director, page	Be C	25. Was case referred to medical examiner?	pital: 1 Innation 2 FR/Outnatio	26.Place of Death (Chant 3 DOA Other N			
	2	1 ✓ Yes 2 No 27. Manner of Death	Inpatient 2 ER/Outpatie 28a. Date of Injury 28b. Time o		ursing Home 5 Res		er. Scene
eath. tor: After t the funeral	ion:	1 Natural 5 Pending	FOUND: FOUND:	1 Yes 2 V No	Subject shot s		
er deat rector by th	icat	2 Accident Investigation	Sep 17, 2007 1830 hrs 28e. Place of Injury - At home, farm, str	reet, factory, office building, etc.			ural Route Number, City
4 hours after des funeral Directo ely filled in by tl	Certification:	3 Suicide 6 Could not be determined	(Specify) Multi-Family Apt.		or Town, State 406 Bayshore Dr	e) ive, Ocean City, N	N D
hor y fil	ledical C	29a. Certifier 1 Certifying Physician:	To the best of my knowledge, death occurrence the basis of examination and/or investig	curred at the time, date and place	, and due to the cause(s red at the time, date and) and manner as sta place, and due to t	ted. ne cause(s)
in 24 he Fi	0	29b. Signature and title of certifier	d manner stated.	29c. License number			
within 24 To the Fu completel	Me	29D. Signature and the parcerune.	Λ ///				
within 24 hours after death. To the Funcral Director: completely filled in by the ft.	Me) n	1. Ct	O.C.M.E.		September 18, 2	2007
within 24 To the Fi	Me	30. Name and address of gerson who com	pleted cause of death (Item 23a) ief Medical Examiner 111 Pr 32. Registrar's Signature	enn Street, Baltimore, MI		September 18, 2	2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Month 12:10 PM arthe mos SAN ptem ber /Medical ,2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ST. Agnes Itospita. Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2X F 216-28-7905 77 Director 11/17/1929 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 □Yes 2 ➡No Baltimore Director Catonsville 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? 715 Maiden Choice Lane CC105 21228 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2√2 No Specify: þ 3 Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sam Malas Lillian Lambros ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary M. Aiello/Sister 25 Hickory Meadow Road Cockeysville, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greek Orth.Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 9/11/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. Wale T. 7 4107 Wilkens Avenue Baltimore 21229 23a. Part1. Enter the dis leaf of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** diseeminated intravascular conculopat 4 hours /Medical Due to (or as a consequence of): Examiner 10015 distributive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Obstructive 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy Peripheral death? 1 ☐ Yes 2 ☐ No performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient ို 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 □Pending investigation 1 Natural Injury 1 □ Yes 2 □ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Records, P.O. Box 68760 Vita

the signed by Division or Hospital or Attending 24 hours after death. the

show

Items 23a or 28a-f shov ner must be notifled at

item 27 is marked other than "natural", or Item other traumatic event, the Medical Examiner

Important: If item 27 i any Injury or other tra Pages 1 ament of He

> burial-transi and

as the attending properties for use as

physician

within 72

2 should be first and Mental F

Baltimore, Maryland 21215-0036

completely 0

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOMORI samue 31. Date filed (Month, Day, Year)



900 Caton Ave, Baltimore, HD 21229

29c. License number

P20661

29d. Date signed (Month, Day, Year)

9/1/0-

ORIGINAL

Medical

(Check only one)

29b. Signature and title of certifier

SFP 2 0 2007

DHMH 17 Rev 1/2001

SINGLETO

MITDREY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death TO Death M Physician dember 18, 2007 ^o/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALLIMORE Altimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**X**M 2□ F 249-50 -48 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avant, the Madical Examiner must be notified at Completed by Funeral Director 1 Yes 2 No ARYLAND HMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò USA 101012 or itams 23a 21223 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced natural AMERICAN TrICAL 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NIA DALHIMLE (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be pe enter Wahield VIRGINIA 19a. Informant's Nam elationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an itam 27 is AUE BATHMORE MARGIANA atterine Smith I mether 2/26 W. MAIRMOUNT other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition = 6 Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If any njury or once. Henrice ack Albutus MALULAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service-Licensee 22. Name and Address of Facility LANCY M, WATTARE 3405 W. FRANKlin St. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician as a consequence of): disease or condition resulting in death) .Va /Medical Due o lo **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due 1 Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events attending physician and as a consequence of): resulting in death) Last Due to (o P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by th 2 should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 1NO 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Certification; To 1 🗌 Yes Other: 21 4 Nursing Home 5 1 Partice 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) eath 28c. Injury at Work? 27. Manner 28b. Time of 28d. Describe how injury occurred After atural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 4 Homicide in by 1 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year)

SEP 2 0 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day William 1408PM September 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore The Johns Hopkins Hospiral Age (In yrs. last birthday, Birthplace (State or Foreign
Country) **Funeral** Hours Months 1 X M 2 ☐ F 62 215-44-0425 **Director** 08-11-1945 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show Iry or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Harford Bel Air 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1705 Hawthorn Ct 21015 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " College (1-4or 5+) Elementary/Secondary (0-12) Electrical Research Engineer John HopkinsUniversity 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Guy Spangler Blanche Bortle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn J. Spangler (wife) 1705 Hawthorn Ct Bel Air, MD 21015 Department of Health Important: If Item 27 any Injury or other troonce, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State -20 - 20074 □ Donation 5 □ Other (Specify) Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Bel 21. Signature of Foneral Service License Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Circhosis 4 months /Medical Due to (or as a consequence of): Examiner Peritonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner Sepais Due to (or as a consequence of) 2 Days Exsangui IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 → No 24a. Was an page 2 s performe 1☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 🗖 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 24 hours after death.

3 altimore, Maryland 21215-0036

within 2 To the

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

00

eurer 600 North Wolfe Baltimile, MA 21287-9/06 Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature

SEP 2 0 2007

(Check only one)

29b. Signature and title of certifie



Dr. Robert Stoltz, M.D. State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Lutherville, MD

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07-0	7000	

Physician	n/	For State egistrar Decedent's Name (First, Mid Caroline Starnes	itate of Maryla	•	rtificate o			R 2. Date of Dea	eg. No.	3. Time of Death
Medical Examine	٠	La. Facility Name (if not instituted the state of the sta	ne- ion, give street and nu	Starne mber)	s -	4b. City, Town, or Cockeysville			Day Year er 11, 2007 4c. County of De Baltimore C	
Funeral Director	- 1	5. Social Security Number		7. Age (In yrs. I	last birthday) Yr	If Under 1 Year Months Days	If Under 24Hr	n.	rth (MM/DD/YYYY) 9.	
w any	[Jsual Residence of Decedent 10a. State 10b. Count		10c. City	, Town or Loca					10d. Inside City Limits 1 Yes 2 X No
the Maryland a or 28a-f sho	Director	0e. Street and Number	timore		Cockeys	10f. Zip Code		. 1	0g. Citizen of What C	
after death with the Maryland al", or items 23a or 28a-f she mer must be notified at once	— L	13801 York Ro 1. Marital Status 1. Never Married 2.	Married 12. Was Dec Armed Fo	2 X No	lf '	as Decedent of His Yes, specify Cuban	panic Origin? (\$, M exican, Puerl	White, etc		
hours	Completed by	Widowed 4 X D 15. Decedent's Education (Sp Elementary/Secondary (0-12)		de completed)	16a. Decede	Yes 2 X No ent's Usual Occupation of working life. of Public	ion (Give kind of DO NOT use re	etired)	Specify: 16b. Kind of Businer Public Re	
215-0036 be filed within 72 ntal Hygiene. rked other than "ent, the Medical I	Be Comp	12 17. Father's Name (First, Midd Richard	le, Last)	Starn	Firm/V	Vriter	•		Maiden Surname) Ely	Tactons
21 thould nd Mei is mai	2	9a. Informant's Name/Relation	nship (Type, Print)	10	19b. Mailii 1380]	-	t and Number or ad, C-9		mber, City or Town, St SVIILe, MI 120c. Location - City	21039
Baltimore, MI permit, Pages I and 2 s Department of Heath a Important: If item 27 injury or other traum		20a. Method of Disposition 1 Burial 2 X Cremati 4 Donation 5 Other 21. Instructor Funer Service	Specify:	om State	crematory or c		9/	14/07		lle, Marylan
Physician /Medical	Y	Bry/a/n W. Clar- 23a. Fe/ I. Enter the disease, failure. List only one caus	or complications hat case on each line. Nat	aused the death	n, Do not enter d venlafa	Ammon Fire	neral Ho onia Ro such as cardiac ication c	ome of D ad. Timo or respiratory ar omplicatin	oulaney Val onium, MD rest, shock, or heart ng	1ey Inc. 21093 Approximate Interval Between Onset and Death
xaminer	Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Las	b. Due to (or as a se c.		of): of):	7/4				
		X UNPENDED	d. X AMENDED	#27,28a-f ,27,perME		8872 9/1/07 TI	6/07 TT		23d. Date of deli	Ven
ision of Vital Records, P.O. Box 6876 Attending Physician: The law requires that the death certificate redeath. retor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be deached for use as the by		Description of the second of	the 1 Live b	pirth nant at time of d	2 F	etal death 3 other (Specify)	Ectopic preg	nancy	Month	Day Year
S, P.O. I	र्ट	Part II. Other significant cond	ditions contributing to	o death but not	resulting in the	underlying cause g	given in Part I.	1 Ye	es 2 No 3 F	e to the cause of death? Probably 4 Unknown
of Vital Records, P.O. B og Physician: The law requires that the d ther this certificate has been signed by the meral director, page 2 should be detached	Completed							1 Yes		e autopsy findings available to completion of cause of n? Yes 2 No
of Vital Physician: er this certi	To Be	25. Was case referred to medi examiner? 1 Yes 2 No 27. Manner of Death	Hospital	Inpatient 2	ER/Outpatier	nt 3 DOA	of Death (Checonomic Other) Nurs	sing Home 5	Residence 6 🗸 O	ther: Scene
Division of a To the Bospital or Attending Physinia 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	Natural 5 Pe 2 Accident Inv	ending (Month vestigation Fnd (n, Day, Year) $9/11/2007$ te of Injury - At h	Fnd 3:	59 am 1 ceet, factory, office b	res 2 X No	unk 28f. Location or Town.	(Street and Number or State)	Rural Route Number, City
	Medical Ce	4 Homicide 29a. Certifier 1 Certifying	Physician: To the best xaminer: On the basis and manner s	st of my knowled of examination	in apar dge, death occ and/or investig	urred at the time, da	ate and place, a	nd due to the cau	ise(s) and manner as a e and place, and due to	stated. o the cause(s)
		29b. Signature and title of cert	M. K.	& THE	m 23a)	29c. Licens	001	МЕ	29d. Date signed (September 11	
Ø Sta		Theodore M. King, J	Ir., MD. Assista	ant Medical egistrar's Signa	Examiner	111 Penn St	reet, Baltimo	ore, MD 2120	1	

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

SFP 2 0 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year a 15 2007 0830 M /Medical Seotember 4b. City, Town, or Location.

Randalls to wn

If I Inder 24 Hrs. 8. C Facility Name (If not institution, give street and number 4c. County of Death Examiner orthwest enter Himore Ba If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Dave | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs last birthday Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F 216-22-4952 Director MD 0 Usual Residence of Decedent 10a State a or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Items 23a must ! 4204 OLD MILFORD MILL ROAD 21208 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner within 72 hours after Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🛣 No WHITE Specify: Specify: 3 ☐ Widowed 4 🏌 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and 2 should be filed within to Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS FOOD INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMIL CASCIO ROSE ပ COHEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLINTON SNYDER / SON 5401 COLLINS AVENUE, #137, MIAMI BEACH, FL 33140 20a. Method of Disposition Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date permit. Pages 1 Department of H Important: If Ite 1 Burial 2 □ Cremation 3 ☐ Removal from State CHEVRA AHAVAS CHESED 09/19/2007 4 Donation 5 Dother (Specify) RANDALLSTOWN, MD 22. Name and Address of Facility 21. Sign Jure of Funeral Service License SOL LEVINSON & BROS., INC. any 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final atherosolerotic **Physician** Cardiovascular resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): physician al Completed by Physician/Medical attending p as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I signed by the a 2 No 9☐Unknown 9 Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, The law requires 2 No 3 Probably 4 Unknown 1 ☐ Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has e 2 page certificate 1□ Yes 1 ☐Yes 2 ☐ No or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 □ DOA ၉ this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After (Month, Day Year) 1 Naturai 5 ☐ Pending investigation 1 ☐ Yes within 24 hours after death.

To the Funeral Director: /
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DO057776 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Sharon Smith 2007 30166 1- For State Certificate of Death Reg. No Registrar 3. Time of Death Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ September 15, 2007 0905 hrs **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 3132 Normount Avenue **Baltimore** 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 6 Sex **Funeral** Foreign Hours Director Country) М 2 XF 76-634 Usual Residence of Decedent IOc. City, Town or Location 10d. Inside City Limits 10b, County iny 1 Yes 2 No Director 10g. Citizen of What Country 10e Street and Number 23a or 28a-notified at Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married Yes Yes 2 X No specify: Divorced If Yes, Give Year ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) be filed within 72 hours Completed Flementary/Secondary (0-12) item 27 is marked other than . Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname M 20b. Place of Disposition (Name of cemetery, Baltimore, 20a Method of Disposition crematory or other place) 2 Cremation 3 Donation 5 Other Specify 21. Signature of Funeral Service License t I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ar Approximate Interval Physician Between Onset and failure. List only one cause on each line. 'Medical Death Cardiac arrhythmia Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of) Carlotta ar F. Sequentially list conditions, if any, leading to immediate. Due to (or as a consequence of): Examine cause: Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical e attending physician for use as the burial -X UNPENDED #23a,PII,27,perME,g872. 10/12/07 TT Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Dav Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown g Unknown the o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown HYpertensive cardiovascular disease: diabetes mellitus Completed Division of Vital Records, funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? No ✓ Yes 2 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ٩ 1 🗸 Yes 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural Yes 2 Pending To the Funeral Director: completely filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 15, 2007 in O.C.M.E. des 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Re State

ORIGINAL

Registrar

		1 - For State Registrar	State of M	larylan		irtment of F <i>tificate of</i>	Health and N <i>Death</i>		giene 20	07	30167
District.		1. Decedent's Name (First, Middle	, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
Physicia /Medic		Clara A. Tille	ette					Sept.	19 200	7	1:16 A M
Examin		4a. Facility Name (If not institution,	, give street and number,)			or Location of Death		4c. County		
P 49	100	Gilchrist			1	Towso		T 0 D 1 (D)		timor	
Funeral Director		5. Social Security Number 214–22–5527	6. Sex 7. A	98	last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da Nov. 11	y, Year)	9. Birthpla Countr MD	ace (State or Foreign ry)
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	cation				10	d. Inside City Limits
Aaryla f sho ed at	ō	MD Baltin	nore	Tin	nonium						1 ☐ Yes 2 No
the N 28a-	Director	10e, Street and Number				10f. Zip Code			10g. Citizen of V	What Countr	ry?
3a or	Ö	12240 Roundwoo	od Rd. #301			21093	3		USA		
death ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. V		Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	14. Race	e - America	
ges 1 and 2 should be filed within 72 hours after death with the Maryland ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. The Maryland and Mental Hygiene. The Maryland is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces' 1 Tyes 2 Till If Yes, Give Year or Dates:	No		Yes 21X No	Specify:	o nican, etc.)	Specify	k, White, etc.	ite
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tal Hy d oth	Be	17. Father's Name (First, Middle, I	Last)				18. Mother's Nam			ie)	
y ca ould Men arke	မှ	George Szeliga					Josephi				
Vian 12 sh h and h is m raum		19a. Informant's Name/Relationsh				-	and Number or Ru				*
c, wan yiano 4 12 1 1 and 2 should be filed within the drait and Mental Hygiene. Hem 27 is marked other than ther traumatic event, the M		Edna E. Tillett	e/daugnter	20b. P			rood Rd.	Date 11	20c. Location -		
Pages 1 and to the control of the co		1 X Burial 2 ☐ Cremation				sition (Name of natory or other pla				•	
		4 Donation 5 Other (Specify) Baltimore National Cem. 9/24/07 Baltimo 21. Signature of Funeral Service See									D
permit. Departr Importa		Michael J.	lagie		10	Lemmon W. Pado	Funeral lonia Rd.,	_Timoniu	ım, MD 2	1093	
		23a. Part1. Enter the disease, or shock, or heart failure. List					ng, such as cardiac	or respiratory a	rest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	_a BLA	00E.	R CA	NCER					7 YEARS
/Medical Examiner		resulting in death)	Due to (or as	s a consequ	uence of):						
	<u></u>	Sequentially list conditions,	b. Due to (or as	s a consequ	uence of).						
ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a a consequ	derice oi).						
xecu al-trar	xar	that initiated events resulting in death) Last	c Due to (or as	s a consequ	uence of):						
icate be executed physician and the burial-transit											
	edical		0.								
death certific	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Dat	te of deliver	у
deat deat	Sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 □Live birth 4□Pregnant a 9□Unknown			Ectopic pregnand Other <i>(specify)</i> _	y		Mo	onth E	Day Year
by the a	پُر	9 ☐ Unknown									
The law requires that the death certification is the strength of the attending page 2 should be detached for use an	þ	Part II. Other significant condition	ns contributing to death l	but not resu	ulting in the un	derlying cause giv	ven in Part I.		obacco use cont ⁄es 2□ No		e cause of death?
w require been si should b	Completed							24a. Was	an 24b.	Were autop	sy findings available
The lav	E C		-						rmed?	prior to com death?	pletion of cause of
siclan: Th certificate rector, pag	BeC	25. Was case referred to medical					26. Place of Dea	1 Yes		1∐Yes 2	2 □ No
ysich iis cer direct	0	examiner? 1 □ Yes 🏖 No	Hospital: 1 ☐ Inpati	ient 2 🗀	ER/Outpatient	t 3 DOA Oth	or.	ome 5□Resid		er (Specify)	HOSPILL
ding Ph h. After th funeral	tion: T	27. Manner of Death 1	28a. Date of Inj (Month, Da		28b. Time of Injury	28c. Inju Wo			now injury occurr		
Atten deat deat y the	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of in	jury - At ho	ome, farm, stre	eet, factory, office			Street and Numb	er or Rural	Route Number,
after after din b	Certification	4 ☐ Homicide determi	building, e	tc. (Specify	y)			City or Tov	vn, State)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical C		g Physician: To the best Examiner: On the basis and manner s	of examinat							
ro the vithin of the complex	Mec	29b. Signature and title of certifier)		29c. Licens			29d. Date signe	d (Month, E	Day, Year)
F S F O		1	1//	in		D	64395		SEPTE	MASS	19.2007
,		30. Name and advace of person	who completed cause of	death (Item	23a) (Type, I			, ,		JUN	24/
4		DANIENE DIBERI	MAN, MU 63	505 P	N CHA	MUZSST,	84112 216	BALT	IMERE, 1	WO 2,	1204
Sta Registr	_	30. Name and address of person of DAN/ENE DIBERT 31. Date filed (Month, Day, Year)	0 2007	ara s Sigila	IS A	and y					

DHMH 17 Rev 1/2001

			State of Maryland / Dep		Mental Hygie	ne 2007	30168								
		_	1 - State Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg.	No. 2007									
	Physic		James Junious Williams		Month	Day Year	3. Time of Death								
	/Medi Examii		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4/2007 4c. County of Death	8:34 A M								
4			Southern Maryland Hospital	Clinton		Prince Ge	orge's								
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		lace (State or Foreign								
L	Director		578-74-1009 51 Yrs.		12/4/195		burg, NC								
	/land ow at		10a. State 10b. County 10c. City, Town or Lo			1	0d. Inside City Limits								
	Man a-fsh ified	ctor	MD Prince George's Colmar Man	nor			1≹ Yes 2 □ No								
	leath with the Marylar ns 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number 3413 37th Street	10f. Zip Code 20722	10g.	Citizen of What Coun	try? USA								
	death ms 23 musi	rera			pecify Yes or No-	14. Race - Americ	an Indian.								
980	72 hours after death with the Maryland natural", or Items 23a or 28a-f show disal Examiner must be notified at	þ	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 🔼 No	Was Decedent of Hispanic Origin? (S _i if Yes, specify Cuban, Mexican, Puerfort 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, Specify: Bla	etc.								
5-0	72 hours "natural"; edical Exa	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	king 16b	. Kind of Business/Inc	dustry								
121	within ene. than '	ldm		kind of work done during most of work DO NOT use retired) Engineer	ang	Desire									
d 2	filed Hygie	ပိ	17. Father's Name (<i>First, Middle, Last</i>)		e (First, Middle, Maid	Private									
ılan	uld be Mental Irked c	To Be	James Williams	Tencie		aon ourname)									
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical once.		19a. Informant's Name/Relationship (Type. Print) 19b. Mailii Valeeta Williams/daughter 4730	ral Route Number, Ci	City or Town, State, Zip Code)										
Baltimore,	es 1 a of Hea fitem rothe		20a. Method of Disposition 1 월 Burial 2 □ Cremation 3 □ Removal from State	osition (Name of matory or other place)	Date 20c	Location - City or To	wn, State								
ţ	t. Pag tment tant: I	rentwood, MD													
Bal	permit Depar Impor any in		Jours Montagnery - Cheatter 3	2 . Name and Address of Facility $$ $$ $$ $$ $$ $$ $$ $$ $$ $$	d., Brenty										
je je			23a. Part1. Erner the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	Physician // // // // // // // // // // // // //		Immediate Cause (Final disease or condition resulting in death) a. ACUTE CURUNARY SYNDROME												
	Examiner		Due to (or as a consequence of):												
7		Jer	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			70									
V	ecuted nd rransit	amir	Cause (Disease or injury that initiated events c												
90,	oe exe cian a rurial-l	dical Examiner	resulting in death) Last Due to (or as a consequence of):												
68760,	icate be executed physician and s the burial-transit	dica	d												
Box (certifi nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			22d Data of dalling									
P.O. Bo	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year								
	s that ned by deta		Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?								
or Vital Records,	requires	ted by	HYPERTENSION		1 ☐ Yes	2 No 3 Proba	ably 4 Unknown								
ec	2 IS a	Completed	DIABETES MALLIATUS		24a. Was an autopsy	24b. Were autop	esy findings available appletion of cause of								
E H	r: The licate hat; page	S.			performed 1 Yes 2 🔀	? death?									
Vit	iding Physician: Th h. : After this certificate funeral director, paç	Be	25. Was case referred to medical examiner? Hospital: Ho	Othor	h (Check only one)										
o	Phys r this ral di	은	1 ☐ Yes 2 No Pospital: 1 ☐ Inpatient 2 DER/Outpatien 27. Manner of Death 28a. Date of Injury 28b. Time of		me 5 ☐ Residence 28d. Describe how in	6 □Other (Specify)								
ion	nding th. r: Afte e fune	tiol	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	Zod. Describe flow if	ijury occurred									
Division	er dea rector by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street building, etc. (Specify)	eet, factory, office	28f. Location (Street	and Number or Rural	Route Number,								
Ö	ital or rs after ral Di led in	Cer			City or Town, St										
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the basis of examination and/or in and manner stated.	o occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)								
	To t withi To tl	_	29b. Signature and title of certifier	29c. License number		Date signed (Month, E									
	,		30. Name and address of person who completed cause of death (Item 23a) (Type, I	D50689	0	9/15/20	V7								
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, I	Print) ANILEMMH	ADAN.A	m2 , c	IAC.								
	Sta		7503 WRATTERD CLIW 31. Date filed (Month, Day, Year) 32 Registrar's Signature	NN MD 20	735-										
State Registrar SEP 2 0 2007 SEP 2 0 2007															

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Amend 25&26, perMD, g871, 9/20/07 TT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 19 **Physician** 1433 Percy Wilson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALYO, MD 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 31, 1931 Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days Months 1 ☑ M 2 □ F Yrs. 76 096-24-9997 Florida Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director MD Prince George's Oxon Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 820 Shelby Drive 20745 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No Specify: black þ 3 Widowed 4 □ Divorced Baltimore, Maryland 21215-00 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk salesperson retail 7 is marked other traumatic event, the permit. Pages 1 and 2 should be file Department of Health and Mental Hy, important: If item 27 is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be Percy Wilson Sr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chanelle Wilson/niece 5629 Regency Park Court #9 Suitland, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state 21. Signature of Euneral Service Licensee Ronald S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23 Part1. Ent the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or host failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (FirmI disease or condition resulting in death) Acute Mysendial **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of: Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed the burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached i 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No page 2 has certificate 12 Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ▼ ER/Outpatient 3 DOA 은 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Latural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760. P.O. I Records, Vital ö Division

ai or Attending P s after death. il Director; After t To u.c. within 24 hours ב. To the Funeral Direct

State

Registrar

Icrance 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Terrance L. Baker Mi) 6 ccd Same 32. Segistrar's Signature LE BLASSE

2007

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th (Item 23a) (Type, Print) to the spill Baltmore on D.

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00058570

29d. Date signed (Month, Day, Year)

September 05 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 30170 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Year September 15, 2007 0920 hrs **Medical Examiner** CHARLES ERNEST WHYE 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A 1617 E. Coldspring Lane 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. Funeral 5. Social Security Number 6 Sex Foreign Country MARY LAND Months Days Hours Min Director x M 2 F Yrs 3-31-1937 70 218-32-9131 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State Ob. County 1 X Yes 2 No BALTIMORE N/A or 28a-f show MD. or items 23a or 28a-f shomust be notified at once. with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21218 1617 E. COLDSPRING LANE Funeral 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. death v Armed Forces? Never Married 2 Married 2X No Yes Specify: BLACK Give Year Yes 2 X No specify Pages 1 and 2 should be filed within 72 hours after Widowed 4 X Divorced the Medical Examiner "natural" ۾ 16a: Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DD NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ ent of Health and Mental Hygiene.

11. If item 27 is marked other than 'other tranmatic event. the Madical 21215-0036 HORSE -0-TRAINER -11-18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) LYDIA WHYE Be DANIEL PAYNE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) M 20 STABLE RUN CT. FOX RIDGE, MARYLAND 21133 EVELYN CURRY-HALE (SISTER) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition ltimore, crematory or other place) 1 X Burial Cremation Department of Important: I MORELAND MEMORIAL PARK 9-21-2007 BALTIMORE, MARYLAND Other Specify Donat HIBN 22. Name and Address of Facility PHILLIPS FUNERAL HOME. P.A. uneral Se 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval and. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a Physician Between Onset and fai are. List only one cause on each line Medical Death a, Atherosclerotic Cardiovascular Disease Immeriate Cause (Final disease ⁵xaminer ndition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician or use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Month Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. signed be be deta ð 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been sector, page 2 should 24a. Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed No Yes 2 V No 26.Place of Death (Check only one) director, 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Other; Residence 6 V Other: Scene DOA Nursing Home 5 this Inpatient ER/Outpatient 3 1 🗸 Yes No After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural Yes 2 Pending Director: d in by the f after death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) within 24 hours at To the Funeral I completely filled determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie September 16, 2007 O.C.M.E Lause 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 200 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Rondalls town Elder Carc Kondallshown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** 227-02-9485 1 □ M 2 😾 F 78 1929 Director June Taiwan Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant; If Item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Exa<u>miner must be notified at</u> 1 ☐ Yes 2 ☑ No Director Maryland | Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1411 Pleasant Valley Drive 21228 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No 3altimore, Maryland 21215-0036 Specify: Asian þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other trainmain. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown Kai ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tzu C. Yang 1411 Pleasant Valley Drive; Catonsville, MD 21228 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town. State 1 ☐ Burial 2 DiCremation 3 ☐ Removal from State 9/28/2007 Metro Crematory Catonsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Sign wire of Mineral Service Licensee 1630 Edmondson Avenue: Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. End stage Immediate Cause (Final disease or condition resulting in death) liver **Physician** /Medical Due to (or as a continuous of): Examiner stage Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transit and Due to (or as a consequence of) Box 68760, ettending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnape 3 Ectopic pregnancy in the past 12 month Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the e 9□Unknown been signed by should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has t autopsy perform certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Laursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2000 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Whatural 5 Pending investigation Injury within 24 hours after deau..

To the Funeral Director: Aft 1 ☐ Yes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitai 29a. Certifier 1 🕩 eertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

DHMH 17 Rev 1/2001

one)

30 Name and address of

31. Date filed (Month, Day, Year)

29b. Signature

and manner stated

person who completed cause of death (Item 23a) (Type, Print)

al 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Liberty Road, Randallsbwn, MD

ORIGINAL

		For State Registrar	State of Ma		d / Depa		of H	lealth	and N		vaion	_		30172
Dharisi		Decedent's Name (First, Middle, La	ast)							2. Date of D		av	Year	3. Time of Death
Physici: /Medic		Herman Karl Zie								Septe	mler	18	2007	748 PM
Examin	er	4a. Facility Name (If not institution, given Upper Chesapeak				4b. City, To	own, or 1 A		of Death	,	4c. County of Death Harford			
Funeral		5. Social Security Number 6.	Sex 7. Ag		as <i>t birthd</i> ay)	If Under 1	Year	If Under		8. Date of E	Birth Day, Year	Т	9. Birthpl	ace (State or Foreign
Director		213-64-3709	Months	Days	Hours	Min.	01-16-	1954		Conn	ecticut			
land bw		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10	d. Inside City Limits
Mary 1-f sho fled a	tor	Maryland Harfor	d	J	oppa	1 DY						1 ☐ Yes 2☐ No		
ith the or 28s	Direc	10e. Street and Number	1 2 1			10f. Zip C							Vhat Coun	ry?
s 23a	Funeral Director	902 Whitaker Mil	12. Was Decedent	Ever in 119	3 12 1	210		lienanic O	rigin? /Sn	acify Voc or N	U.S.		e - America	n Indian
fter de r item iner r	Fun	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces? 1 Yes 2 1			13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					10-		k, White,	
ours a	d by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:			1 ∐ Yes 2]	_	Specify	:			Specify	Whi	te
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	lete	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give	dent's Usual kind of work DO NOT use	done of	durina mo.	st of work	king	16b. ł	Kind of Bu	isiness/Ind	ustry
	Completed	Elementary/Secondary (0-12)	Elementary/Secondary (0-12) College (1-4or 5+)								Har	ford	Roof	ing Co.
e filec al Hyg d othe	To Be Co	17. Father's Name (First, Middle, Las	t)					18. Moth	er's Nam	e (First, Midd	le, Maide	n Surnam	ne)	
Ment Ment Marked Marked Marked		Herman K. Ziema			405 84-95	4-1-1 (C44			Longr			04-4- 7:-	0-1-1
nd 2 sh Ith and 27 Is n traun		19a. Informant's Name/Relationship Sarah Ziemann (D	aughter)			,				Joppa M			State, Zip	Code)
s 1 ar of Hea Item 3		20a. Method of Disposition		20b. Pl	ace of Disoo	sition (Name	of	- :		Date			City or To	vn, State
Page ment c ant; If ury or		1 ☐ Burial 2 🖾 Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci			view (Cremat	ory	. (4-2007	!			aryland
permit. Departi Importa any Inj once,		21. Signature of Funeral Service Lice	ensee											of Bel Air
ED = 6 0		23a. Part1. Enter the disease, or con	nplications that caused	the death						il Rd E		ir,	MD 21	Approximate
Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each li	ne.			- 5	in .		ular	10	1001	ادھ	Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as								11110-01			
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eath certificate be attending physicië for use as the bu	dica	d												
certifi nding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Dat	e of delive	ry .
death e atte	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	1∐Live birth 4∐Pregnant a 9∐Unknown			□Ectopic pred □Other (spec		/				Mo	nth	Day Year
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ding I h. After funer	tion:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da		Injury	M 200	c. Injur Worl	yau k? Yes 2.[]No	280. Describe	e now inju	ury occurr	eu	
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ital or rs afte ral Dir led in														
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	f examinat	vledge, deat ion and/or in	h occurred at vestigation, i	t the tir n my c	me, date a opinion, de	and place, eath occu	, and due to th rred at the tim	ie cause(s e, date ar	s) and ma nd place, a	inner as st and due to	ated. the cause(s)
ro the Fo the Fo the Somple	Mec	29b. Signature and title of certifier	and mariner se			29c.	Licens	e number			29d. Da	ate signed	d (Month, I	Day, Year)
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11		30. Name and address of person who	completed cause of d	leath (Item	23a) (Type,	Print)	וות	1/5 1	- ^	1 20	1 11	. 1/1	11 .	11 112
Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signat	1614 ure	CHYN	CH	VILL	EK	d. BE	: L M	IR I	Nd =	1115
Registr			0 2007	13.0	18	Mank	20							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 30173 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2007 Year Month 15, 1948 Sept. Stephen Zuck Walter 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 8. Date of Birth (Month, Day, Year) Prince George's Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 MA 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex Hours 1□M 2□F 80 029-16-4973 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Clinton Maryland | Prince George's 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20735 11406 Accolade Court 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Never Married 2 🛛 X arried Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Logistics /Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stephen Zuck Press Stephanie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stella Ann Zuck (wife) 11406 Accolade Ct. Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov. 20 Arlington National Cem. Arlington, Virginia 2007 21. Signature of June ice Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road, Clinton MD 20735 Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final disease or condition resulting in death) Due to (or as a consequence f) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 🗗 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes 6 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? ' Year) (Month, Day 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

2

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

other traumatic event,

permit. Pages 1 and 2 should be fi Department of Health and Mental I-Important: If Item 27 is marked ott any Injury or other traumatic even

1 and 2 should be Health and Mental

filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-trar and signed by the a

funeral director. Hospital or Attending nours after death.

neral Director: A
filled in by the fu death.

Division or Vital Records, P.O. Box 68760,

Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ALTheim 25. Was correferred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

1328

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Bolello

M D 132. Regarda's Signature

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Registrar

within 24 hours at To the Funeral C completely filled i

Southern Aug SE. DC

State of Maryland / Department of Health and Mental Hygiene [] [] 7 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 30 Irving Durphy Abell Aug. 2007 8:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Fairfield Nursing Center Crownsville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Wash., D.C. 8. Date of Birth (Month, Day, Year) DeC. 4,1929 5. Social Security Number 6. Sex **Funeral** 1⊠M 2□F Months Days Hours Min Yrs. 579-38-1466 77 Director Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28e-f ehov r then "neturel", or iteme 23a or 28e-f eho the Medical Examinar must be notified at 1 Yes 2 □ No Director Prince George's Bowie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20716 3015 Nutwood Lane Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Yes 2 No 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1951–59 1 ☐ Yes 2X No Specify: Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trucking Driver Pages 1 and 2 should be filed without of Health and Mental Hygien trant: If Item 27 Ie marked other th jury or other traumatic event, Ins. 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Manuel C. Abell Lena Grave Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley A. Abell / spouse 3015 Nutwood Lane Bowie, MD. 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. Metropolitan Crematory 09/05/2007 Alexandria, VA. 21. Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home 20715 Duan 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner physiclen and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as the l IF FEMALE: for use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♥ No 24a. Was an autopsy performed 2 No 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident М investigation Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide To the Hospital of within 24 hours at To the Funerel D filled 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of pertities 29c. License number 29d. Date signed (Month, Day, Year) rsen who completed cause of death (Item 23a) (Type, Print) Olin Burnie MO21061 Lighway ille My 31. Date filed (Month, Day, Year) 32. Registrar's Sic State 2007 SEP 0

Registrar

6

State of Maryland / Department of Health and Mental Hygiene 1- State Amend #26 &29d per PHYS/FH 09 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9:20P. M Multa 31 ay 2007 **Physician** Amy Louise Ahalt /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick 50 Pennsylvania Ave. 9. Birthplace (State or Foreign 1972 Country MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

(Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 X 34 218-72-2608 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10b. County ia or 28a-f show t be notified at Jefferson 1X Yes 2 No Frederick MD **Funeral Director** should be filed within 72 hours after death with the Find Mental Hygiene. marked other than "natural", or items 23a nr 28a-10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21755 USA 3806 Jefferson Pike ms 23a 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 is marked ott Be Louise Elizabeth Specht Amos Benjamin Ahalt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3806 Jefferson Pike, Jefferson, MD 21755 permit. Pages 1 and 2 s
Department of Health ar
Important; If Item 27 is
any Injury or other trau Louise Ahalt (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition N Burlal 2 Cremation 3 Removal from State Reformed cemetery 9/6/07 Jefferson, MD 4 Donation 5 DOther (Specify) ignatu e Jun ra 9 rvice Lic ²² Name and Address of Facility Donald B• Thompson Funeral Home 31 E. main St., Middletown, MD 21769 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Part1. Enter the disease, or shock, or heart failure. List Onset and Death Immediate Cause (Final disease or condition resulting in death) MD **Physician** PICATI /Medical Due to (or as a consequence of): Examiner 12 Sequentially list conditions, if any, learning to immodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a non-Examiner be executed burial-transit and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the a 9 Unknown 9 ☐ Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, by 1 ☐ Yes 2 ☐ Yoo 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed performed certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home Synesidence 6 Other County Living Inc. Be 1 Tyes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? lospital or Attending P hours after death. uneral Director: After t After 1 Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 9/4/07 29c. License number 29b. Signature and title of certifier D0031058 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name an oppermine Rd. Woodsboro. Mb 31. Date filed (Month, Day, State SEP 0 7 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Bernice Rose Azzinaro September 2007 09:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Burnie Baltmore Washington Glen Arme Arundel Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) West Virginia 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🕅 F 189-24-1163 90 Director 12,1917 Usual Residence of Decedent 10a State 10c, City, Town or Location or 28a-f show notified at 10b. County 10d. Inside City Limits MD Anne Arundel Severna Park 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n USA 465 White Cedar Lane 21146 Completed by Funeral ıral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify: White Specify: Pages 1 and 2 should be filed within 72 hours ament of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural"; oury or other traumatic event, the Medical Exan 3 \ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Home** Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frances R. Kwasny Joseph F. Shemenski 2 19a. Informant's Name/Relationship (Type. Print)

John C. Mahoney/ Grandson 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zin Code, 1715 Manor Place, Clementon, New Jersey 08021 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot Saints Peter and Paul Sept. 06, 1 X Buria! 2 ☐ Cremation 3 ☐ Removal from State Springfield, PA Cemetery
22. Name and Address of Facility
8. Sons 2007 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Accident Cerebrornscular resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed and use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 5 Other (specify) 1 ☐ Yes 2 No should be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 performed' this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 1 Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division or Vital Records, P.O. Box 68760, Attending Physician: within 24 hours after death To the Funeral Director:

Baltimore, Maryland 21215-00;

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State Registrar

MO trancis

3. Registrar's Signature

29c. License number 29d. Date signed (Month, Day, Year) DO27415

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

word MD

Washing for Medical Center PAltimore

31. Date filed (Month, Day, Year) SEP 0 5 2007

29b. Signature and title of certifier

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ral", or items 23a or 28a-f shov Examiner must be notified at

'natural", or items 23a

than .

f Health and Mental Hygiene. Item 27 Is marked other thar

permit. Pages 1
Department of H
Important: If iter
any Injury or oth

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

Be

2

Examine and attending physician Physician/Medical Completed by Be this Certification: To After

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Death 2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 5 □ Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔍 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

within 24 hours after death

To the Funeral Director: ,
completely filled in by the f State Registrar

the Hospital

Medical

31. Date filed (Month, Day, Year) SEP 0 6 2007

29b. Signature and title of certific

(Check only one)

14300 Gallant Fox Lane Rakesh Arora, M.D. 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Mogth, Day, Year)

20715

Bowie, MD.

State of Maryland / Department of Health and Mental Hygien 2 0 0 7

Certificate of Death Reg. No. 30178 1 - For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month :05 PM Physician FREEMAN DRANBL 2007 EBECCA LYNN SEPT. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner QUEEN PRINCESS ANNE ANNES CHESTERTOUN MO DRIVE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days 49 231 96 6215 Director APKIL Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No ANNES QUEEN CHESTERTOWN Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21620 U.S.A 200 PRINCES ANNE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status t and 2 should be filed within 72 hours after with and Mental Hygiene. em 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: WHITE 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT 4 CCOUNTA UBLIC 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) RAYMOND KUTH ELIZABLTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar important: If item 27 is any injury or other trau <u>once</u>. BRANSU P.O. BUX 278 CHESTERTOWN, MD 21620 FICHARD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 09/06/2617 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESTER ¹ 4 ☐ Donation REMATER 21. Signature of Juneral Service Licenses RIARRY AND Address phracility Ms, JR FUNEUR DEKTIN ZICZO CRESA HEREN WAY CHESTERTOWN MD Wel 23a. Part1. Firter the disease, or complications that is used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Q /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as signed by the attending d be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ς, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown been signature Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has be 2 autopsy page performe this certificate 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Be Other: 10 1 Inpatient 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 3 DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral L 🛩 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manifer stated. License numbe 29d. Date/signed (Month, Day, Year) 29b. Signatur d title of cert D0060301 10 cause of death (Item 23a) (Type, Print) Speer Rd. Stee 5 Chestertown, MD MD 122 eimer ichael 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar 2007

State of Maryland / Department of Health and Mental Hygien 2 0 0 7

Certificate of Death Reg. No. 2. Date of Death SEPTEMBER 02, 2007 3:27P M HELEN ELIZABETH BOGGS 4c. County of Death 4b. City, Town, or Location of Death

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last)

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 28a-f show must be notified ō 0, "natural",

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

The law requires that the death certificate be execute attending physician and for use as the burial-trai Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

4a. Facility Name (If not institution, give street and number) PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CLINTON 8. Date of Birth (Month, Day, Y) FEB. 02, 9. Birthplace (State or Foreign 5 Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year Days Hours 1 □ M **X2X**□ F WASHINGTON, DC 1924 578 26 9130 83 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits YYes 2□No Director MD PRINCE GEORGES SUITLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3901 SUITLAND ROAD #213 20746 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes AXXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes XX No Specify. Specify: BLACK þ XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH HOMEMAKER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked o JAMES YOUNG ANNE KING 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. GREENBELT, MD 20770 LENORA REEVES / DAUGHTER 9181 SPRINGHILL LN. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State XI Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMORIAL PARK 09/07/2007 LANDOVER, MD Sonature of Funeral Service License 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND: INC. YY 4308 SUITLAND ROAD SUITLAND, MD 20746 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE PUT HIGH OUT Unknowy Due to (or as a consequence of) Anemia of Chronic Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy 2 No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 X Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43446 9.3.07 Reiter 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ia An suit 3-41 Silver spring MD FARAHIFAR 9801 Georg ROINTAN

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygier 007Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Alice September Bird 2007 5:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Waldorf Charles 2740 Hale Court | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | Z1, 1951 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 21 F 56 223-80-2534 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show r than "natural", or Items 23a or 28a-f shov the Medical Examinatives that he notified at 1 ☐ Yes 2 ☐ No Maryland Charles Waldorf Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2740 Hale Court 20603 USA 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 ☐ Yes 2/17 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 Hygiene. Elementary/Secondary (0-12) 1 year (1-4or 5+) Secretary Federal Government s 1 and 2 should be filed w if Health and Mental Hygier Item 27 is marked other th other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herzig Ignatz Jolante Kumde1 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar
Important: If Item 27 is
any injury or other trau Charles H. Bird Jr. Husband 2740 Hale Court Waldorf, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 Øcremation 3 □ Removal from State Kalas Crematory Sept. 6,2007 Edgewater, MD ⁴ 4 □ Donation 5 ☐ Other (Specify) 21. Signature 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. uneral Service Licen 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ope cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LOS Physician 2 C /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus & Disease or highly that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physicien Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy Por in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) o detached 9□ Unknown 9 Unknown ģ ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ phknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan has page 2 autopsy performed? (es 25 No certificate 1 ☐ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 An esidence 6 Other (Specify) 2 1 Yes 2 No this filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 1-ENatural 2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D28 32 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ris an Mathur, M 0 SEP 0 6 2 31. Date filed 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2007 9:24 Brann <u>September</u> Herbert /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick 8312 Sharon Drive Urbana If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year Nov. 3, 19 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Months 1 ★ M 2 🗆 F 64 577-58-6570 Nov. 1942 Washington, D.C. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or Items 23a or 28a-f shovedical Examiner must be notified at Maryland Frederick Urbana 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21704 USA 8312 Sharon Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No white Specify Specify: δ 3 Widowed 4 Divorced er than "nature the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Electrical Engineer Army Research Lab 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If item 27 is marked oth any injury or other traumatic even once. Be and Mental Andrew Marion Brann Hannah Hall မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Brann - wife 8312 Sharon Drive, Urbana, Maryland 21704 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9-8-2007 Mt. Olivet Cemetery |Frederick, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Sig/ tyre of Funeral Servi 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

Min 1 Immediate Cause (Final Small Cell CANCH Physician /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trai resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dead 2 ☐ Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) ☐ Yes 2☐ No 9 Unknown Ś signed ! Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Hypendensi 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be To the Hospital C. Geath.
within 24 hours after death.
To the Funeral Director: After this ce Other: 4 Nursing Home 5 Residence 6 Other (Specify, 20 No 1 🔲 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Mcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ю 21702 56 Thomas Johnson Drive, Frederick, Maryland Joseph Ashwal , M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 7 2007

32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NZ U U Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year **Physician** Day 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Medical Cente ltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1**X**M 2□ F Director 218-40-6351 NOV.21,1942 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD **OUEEN ANNE** STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 106 FOREST GARDEN ROAD 21666 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. Black, White, etc 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: <u>م</u> 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **SEAFOOD** WATERMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOSEPH BAXTER DOROTHY LEE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARON BAXTER/ WIFE 106 FOREST GARDEN ROAD, STEVENSVILLE, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State STEVENSVILLE CEMETERY 9-10-2007 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed Yes 2 No 1□ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient မ 2 ER/Outpatient 3 DOA After thi funeral of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: d in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) LP Limmona 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) e 22 S. GREENE ST., BALTIMORE, MD 21201

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registe

2007

			1 - For Amend	#10g, 1	State o 8 , 9-6-	f Marylan 07, pe r	id / Depa	artment of H	lealth and beath	Mental Hy	giene Reg. No	7007	30183
-1			1. Decedent's Name ((First, Middle, Las	t)					2. Date of D	eath		3. Time of Death
	Physici /Medic		Susan Bar	ran						Month Septem	Day ber 4	Year 4. 2007	2:37 A M
	Examin		4a. Facility Name (If n		street and nur	mber)		4b. City, Town, or	r Location of Deat			County of Death	2.57 11
			Shady Grov					Rockvill				on t gomer	
Į.	Funeral Director		5. Social Security Nur 040-36-244	4	ex □M 2 X 7F	7. Age (In yrs. 63		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, D Februa	rth ay, Year)	Cou	place (State or Foreign ntry) MA
-			Usual Residence of D			0.5				rebrua	шу 4:	, , , , , , ,	TIA
	ylanc how		10a. State	10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	e Ma 3a-f s tiffied	Director	MD N	Montgome	сy	Ger	mantow	n					1 □ Yes 2 🙀 No
	vith th	Dire	10e. Street and Numb	oer				10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	s 23e	era	19004 Not	ole Oak I		edent Ever in U	C 12	20874	ionania Origina /9	Specify Ves or N		2. Race - Americ	
	ter de liner r	Funeral	11. Marital Status 1 ☐ Never Married	d 2□ Married	Armed Fo	rces?		Was Decedent of H If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	0-	Black, White,	
920	urs af	by	3√ Widowed 4		1 □ Yes If Yes, Giv Year or D	veX ates:		1 □ Yes 2 □XNo	Specify:			Specify: Whi	te
21215-0036	be filed within 72 hours after death with the Marylan ttal Hygiene. Ind other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	(Specifi	5. Decedent's Ed	ucation de completed)		16a. Dece	dent's Usual Occup	ation during most of wo	rkina	16b. Kir	nd of Business/In	dustry
2	rithin ne.	mple	Elementary/Second		College (1	1-4or 5+)		kind of work done of NOT use retired	1)		Own	Home	
2	iled v Hygie ther t		12 17. Father's Name (F	irst Middle Last)			Homem	aker	18. Mother's Na	ne (First, Middle			
Maryland	should be filed within 72 hours after death with the Maryland and Mental Hygiene. I warked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	To Be	Theodore						Stephar	· ·	elva (,	
ar _y		F	19a. Informant's Nam	ne/Relationship (7	Type. Print)		19b. Mailii	ng Address (Street	and Number or R				Code)
	1 and 2 Health a tem 27 is		Stephanie	Deia, Da	aughter		19004	Noble Oa	ak Drive	German	town,	, MD 208	74
ore.	of He of He fitem		20a. Method of Dispo		-	20b. F	Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)	Date	20c. Loc	cation - City or To	own, State
altimore,	Pages ment of ant: If It ury or o		4 □ Donation 5	Other (Specif))	Che	sapeak	e Cremato	ry 9/6	5/07	Be1t	sville,	MD
Ball	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Fund) 0 11	see	1	G	2. Name and Addre oing Home		lon Serv	ice	PO Box	784
			232 Part Fotor the		lesser that o	MO12	51 B	everly L.	_Heckrot	te. P.A	C1		1e, MD_2102 Approximate
		0 1	23a. Part1. Enter the shock, or heart Immediate Cause (Fi		one cause on e	each line.	II. DO NOT EIN	ter the mode of dyn	ig, sucii as caidia	c or respiratory	arrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)			monia (or as a conseq	uenco of):						7 days
	Examiner				. Due to	(or as a conseq	derice or).						
		ner	Sequentially list cond if any, leading to imm cause. Enter Underly	ditions, nediate	Due to	(or as a conseq	uence of):						
	ecuted nd transi	Examiner	that initiated events resulting in death) La	jury	C								
90,	cate be executed physician and the burial-transit		resulting in death) La	ist.	Due to	(or as a conseq	uence of):						
58760,	icate be executed physician and the burial-transit	dical			d								
_	leath certifi attending I for use as		IF FEMALE:		23c. If yes, out	tcome pf pregna	ancy				,	3d. Date of deliv	en/
.O. Box	death atter	Physician/M	in the past 12 m	nonths?	1 ☐ Live b	oirth 2 Feta nant at time of c	al death 3	□Ectopic pregnancy □ Other (specify)	/			Month	Day Year
Ö.	at the de by the a tached t	hysi	1 □ Yes 2 ▼ 9 □ Unknown	NO	9□Unkn	own							
S, D	as the	by P	Part II. Other signific	ant conditions o	ontributing to d	eath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute to t	he cause of death?
Records,	w require been sic should b	ted	Stroke					<u>.</u>		1	Yes 2	No 3∏Pro	bably 4 Unknown
Ö	has be	Completed								24a. Wa	opsy	24b. Were auto	opsy findings available ompletion of cause of
		Con								per 1□ Yes	formed? 2 XNo	death? 1 ☐ Yes	2 X No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referre examiner?	1	Hospital:			oth Oth	or:	ath (Check only			
ō	Phys this ral dii	- T	1 ☐ Yes 2 ☐ N 27. Manner of Death	lo	28a. Date		ER/Outpatier 28b. Time o	IL 3 DOA	4 LI Nursing I	Home 5 ☐ Res 28d. Describe		Other (Speci	fy)
o	Attending Ph r death. ector: After th by the funeral	tion	1 Natural 2 Accident	5 ☐ Pending investigation	(Mon	th, Day Year)	Injury	Wor	k?¨ Yes 2 ∐ No	200. 200000	Tion injury	, 000000	
Division or	or Attendatter death Director: in by the	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	Zoe. Flace	of injury - At h		reet, factory, office		28f. Location	(Street and	d Number or Run	al Route Number,
á	safter safter al Dire	Certification:	4 _ Homeldo		bulla	ing, etc. (Specia				Ony or re	own, State)	,	
	d hour		(Check only 2	IX CertifyIng Ph ☑ Medical Exam	ysician: To the	e best of my kno easis of examina	owledge, deat ation and/or in	h occurred at the til	me, date and place	e, and due to the	e cause(s)	and manner as	stated. to the cause(s)
	To the Hospital or A within 24 hours after To the Funeral Direction completely filled in by	Medical	one) 29b. Signature and ti			ner stated.		29c, Licens				e signed (Month,	
\	S S S		A. 114		\sim	/ ~ -		D0066				e signed (<i>Month</i> , cember 4	
6	A) 0-		30. Name and address	eckly (ompleted caus	se of death (Iter	n 23a) (Tyne				- Sept		, 4007
(J No		Meenakshi		1			enter Dri	lve, Rock	ville,	MD 20	0850	
	Sta	te	31. Date filed (Month	, Day, Year)	32. F	Registrar's Signa	ature						
	Registr	ar		SEP 06	2007	Esser	H.	Soull ,					

			1- For State of Maryla		artment of H			giene Reg. No. 20	7 30184
	Physici		Decedent's Name (First, Middle, Last) Joe Felix Brooks				2. Date of De Month	ath	3. Time of Death 4:15am
	/Medic Examir		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center			polis	th	4c. County of	Death Arundel
	Funeral Director		5. Social Security Number 420-36-8993 Usual Residence of Decedent 5. Sex 7. Age (In yr 7) 7. Age (In yr 7)	7 Yrs.	If Under 1 Year Months Days	Hours Min		/ 1929	9. Birthplace (State or Foreign Country) Alabama
	he Maryland 28a-f show otified at	ector	10a. State 10b. County 10c. (City, Town or Lo				10g. Citizen of Wh	10d. Inside City Limits 1 □ Yes 2X No
	3a or 3	D.	959 Gambrills Lane		2105	4		US	,
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Heatth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married * Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 13. Widowed 4 □ Divorced	orea	Nas Decedent of Hi f Yes, specify Cuba l □ Yes 2000 No	spanic Origin? (in, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14. Race Black,	American Indian, White, etc. White
21215-0036	within 72 ho ene. than "natu he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2	(Give life. L	dent's Usual Occupa kind of work done o DO NOT use retired alesman	during most of wo	orking	16b. Kind of Busi	ness/Industry
land 2	uld be filed fental Hygi rked other ifc event, ti	To Be Co	17. Father's Name (First, Middle, Last) James Carlton Brooks		alesman_		me (First, Middle	Maiden Surname,	
\geq	1 and 2 shou Health and M Iem 27 is man other traumat		19a. Informant's Name/Relationship (Type. Print) Ruth C. Brooks Wife		ng Address <i>(Street a</i> Gambrills				
Baltimore,	a ji ji ji		1 Burial Cremation 3 Removal from State	etro Cre	natory or other plac		Date 1/2007	20c. Location - C	ity or Town, State
Balti	permit. Pag Department Important: It any Injury o		21. Signature of Foneral Service Licenses		Name and Addres Ridgely		•		lome, P.A.
	Physician /Medical		resulting in death)	monio		g, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
8760,	eate be executed many invision and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons Due to (or as a cons	Ke equence of):					
P.O. Box 68	The law requires that the death certificat tte has been signed by the attending phy age 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnant at time of the past 12 months? 4 □ Pregnant at time of the pregnant at time	etal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery h Day Year
	quires that in signed by uld be deta	þ	Part II. Other significant conditions contributing to death but not recovery Artery Discesse	esulting in the ur	nderlying cause give	en in Part 1.	23e. Did 1		oute to the cause of death? B Probably 4 Vinknown
or Vital Records,	The law re ate has bee page 2 sho	Completed					24a. Was auto perfo 1∐ Yes	psy pr prmed? de	ere autopsy findings available for to completion of cause of ath? Yes 2 \(\) No
Vita	Physiclan: this certificatal director,	Be	25. Was case referred to medical examiner? Hospital: Hospital:		oth	or:	eath (Check only		
on or	ng ifter	tion: To	1 Yes 2 No 10 No 1 1 Inpatient 2 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 2 1 Accident 10 No 1	28b. Time of Injury	28c. Injur	4 Nursing		dence 6 Other	
Division	al or Attendi s after death. al Director: A	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - Al building, etc. (Spe	: home, farm, str ecify)	eet, factory, office		28f. Location (City or To	Street and Number wn, State)	r or Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my leading and manner stated.		vestigation, in my o	pinion, death oc		, date and place, a	nd due to the cause(s)
	X CO,	≥	29b. Signature and title of certifier		29c. Licenso	1829		29d. Date signed	(Month, Day, Year)
	10,6g		30. Name and address of person who completed cause of death (II Peynaldo Lee Llace II, M.) 31. Date filed (Month, Day, Year) 32. Registrar's Signary	tem 23a) (Type,	Medecil	Partine	, Anna	alis ME	21401
	Sta Regist		31. Date filed (Month, Day, Year) SEP 0 4 2007	K 1	had .				

Registrar DHMH 17 Rev 1/2001 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Adrienne Cunningham 3(2007 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Health Center Bowie Prince Boure Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🛣 F Months 51 Director 215-66-6897 May 17 1956 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show odeal Examiner must be notified at Prince George's Bowie 1 Yes 2 No Md Director with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20716 1408 Post Lane Pages 1 and 2 should be filed within 72 hours after death anent of Health and Mental Hygiene.
ant: if leam 27 is marked other than "natural", or items 23, and it if leam 27 is many or other traumatic event, the Medical Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Homecare Nurse Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Corrine Adams Maurice Watkins ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important; if Item 27 is any injury or other trau 1408 Post Lane Bowie, Maryland Frank Cunningham/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/10/2007 Harmony Cemetery Landover, Maryland 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Finner at Se 7474 Landover Road Landover, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Inonan Physician /Medical Due to (or as a consequence of **Examiner** Complications Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ bnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed certificate 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2FTER/Outpatient 3□ DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Sta

State Registrar

SEP 0 6 2007

31. Date filed (Month, Day,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - State Registrar	of Maryland		artment of H		d Mental H	ygiene Reg. No 2007	30188
			Hegistrar 1. Decedent's Name (First, Middle, Last)			Timoate or E	Jean	2. Date of D		3. Time of Death
	Physici		Joan Frances Cox					AUG.	26, 2007 Year	
	/Medio		4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or	Location of D		4c. County of Dea	
	LAGIIII	38.	7164 Laurel Grove	Road		Prest	on		Car	oline
•	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hours		lirth 9. Bir Day, Year) C	rthplace (State or Foreign country)
ä	Director		215-34-2083 ^{1□M 2} ■ 1□M 2 ■ 1□M 2	70	Yrs.	WOTHINS Days	Hours	Sept.	10, 1936Mar	yland
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation				10d. Inside City Limits
	laryla shov	'n	MD Caroline	Toc. Oity,		ceston				1 ☐ Yes 2x ExNo
	the M 28a-f iotifie	ecto	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	
	with a or	Funeral Director	7164 Laurel Grove	Road			1655		United S	-
	leath ns 23 mus	era	11 Marital Status 12. Was E	ecedent Ever in U.S.	13.			? (Specify Yes or N		
(0	be filed within 72 hours after death with the Maryland tial Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		Armed 1 □ Never Married 2 □ Married 1 □ Ye	Forces?		Nas Decedent of Hi f Yes, specify Cuba		uèrto Rican, etc.)		
Ö	al', o	by	3 ☐ Widowed 4X ☐ XOivorced If Yes, Year o	Give r Dates:		1 □ Yes 2 1 No	Specify:		Specify: W]	hite
2	72 ho natul	Completed	15. Decedent's Education (Specify only highest grade complete		(Give	lent's Usual Occupa	lurina most of	workina	16b. Kind of Business	s/Industry
2	ithin ne. nan "	dr.	Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	`life. I Coo	DO NOT use retired)		Fast Food	d Shon
2	iled w Hygie ther t		17. Father's Name (<i>First, Middle, Last</i>)				18 Mother's	Name (First Middle	le, Maiden Surname)	
Maryland 21215-0036	I be f intal i ed of	Be	John Francis Ecke:	rt					e Adkinson	n
2	hould nd Me mark matic	ဥ	19a. Informant's Name/Relationship (Type. Print)		19b Mailir	ng Address (Street a			ber, City or Town, State,	
<u>8</u>	nd 2 s Ith ar 27 is rtrau		Michael B. Cox/Son			-			Preston, 1	
<u>a</u>	f Hea		20a. Method of Disposition	20b. Plac	ce of Dispo	sition (Name of natory or other place	i	Date	20c. Location - City o	
9	Pages ent o nt: If i		1 ☐xBurial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (<i>Specify</i>)			Mem. Cem.	08	/29/07	Sykesville,	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	bus	22	. Name and Addres	s of Facility	ramptom l	Funeral Home burg, MD 21	e, P.A.
			23a Part 1 Enter the disease or complications th	at caused the death						
			23a. Part1. Enter the disease, or complications th shock, or heart failure. List only one cause of Immediate Cause (Final	n each line.	-1 -day-1	Atmost a		11 1111	F. Shirt warm Arriva	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition a.	to (or as a conseque	25/1	MOME	MILLI	MONTHY	DISTAN	
	Examiner			to (or as a conseque	1100 01).					
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a conseque	nce of):					
	cuted id ansit	Examiner	Cause. Enter Onderlying Cause (Disease or injury that initiated events							
o,	e exer an ar irial-ti		resulting in death) Last Due	to (or as a conseque	nce of):					
8760,	ficate be executed physician and s the burial-transit	dical					100			1
9	ertific ing p	Mec	IF FEMALE:							1
Box	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 menths?	outcome pf pregnand re birth 2 ☐ Fetal d	eath 3				23d. Date of de Month	elivery Day Year
	he de the s	ysic	1 D Vac 2 V No 4 P	egnant at time of dea Iknown	itn 5∟	Other (specify)				•
٦.	that the ed by detac	P	Part II. Other significant conditions contributing t	death but not resulti	ng in the ui	nderlying cause give	en in Part I.	23e. Did	tobacco use contribute t	to the cause of death?
Records, P.O	w requires that been signed to should be deta	d by						1	Yes 2 No 3	robably 4 □Unknown
Ö	v requestions	ete						24a. Wa	s an 24h Were s	autopsy findings available
Ř	slcian: The law certificate has t irector, page 2 s	Completed						— aut	opsy prior to death?	completion of cause of
Vital			25. Was case referred to medical				OC Diago of	1 Yes	2XNo 1 ☐ Ye	s 2□No
	yslcian: The l is certificate ha director, page	o Be	examiner?	☐Inpatient 2☐EF	R/Outpatien	t 3 DOA Othe	er:	Death (Check only	sidence 6 □Other (Spe	noifu)
Ö	g Phys er this eral dii	n: To	27. ann of eath 28a. Da	ate of Injury 2	8b. Time of				how injury occurred	ecity)
<u></u>	nding lath. r: After e funer	aţjo	1 → atural 5 □ Pending (A coident investigation	lonth, Day Year)	Injury		r ∕es 2 □ No			
Division or	Atte er dec recto by th	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pl	ace of injury - At homididing, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location	(Street and Number or F	Rural Route Number,
	tal or A s after al Dire ed in b	Certification:		manig, etc. (epecity)				Oily or 1	omi, ciato,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is	Medical	29a. Certifier (Check only one) 1 ertifying Physician: To Medical Examiner: On the and medical Examiner.	the best of my knowle basis of examination anner stated.	edge, death n and/or in	n occurred at the tim vestigation, in my o	ne, date and p pinion, death	lace, and due to the occurred at the time	e cause(s) and manner a e, date and place, and du	as stated. ue to the cause(s)
	To the within To the complex c	Me	29b. Signature and title of certifier	21		29c. License	number		29d. Date signed (Mon	nth, Day, Year)
}			· fthin	20 M.	1).	Dex	6636	863	AUGUST à	26,2007
7			30. Name and address of person who completed of		3a) (Type,	Print)				
			STEPHEN/RUALO, N	14) 600		FAN LN.	DENTO	N, MAR	YLANDAL	629
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 8 7007	Registrar's Signatur	re	· · · · ·				

			1 ⊶ For State Registrar	State of Maryla		artment of I rtificate of			ien 2007	30189
	Physici /Medic		Decedent's Name (First, Middle, Last)	RUTH EVELYN	CREAGI	ΣR		2. Date of Deat Sept.	Day 200 ^{Year}	3. Time of Death 2:08 AM
	Examin		4a. Facility Name (If not institution, give st. Homewood at Crumlar	nd Farms		4b. City, Town, Freder:			4c. County of Death Frederic	
	Funeral Director		5. Social Security Number 6. Sex 216-54-8112	VI 2√F F 7. Age (In yrs	s. last birthday) 95 Yrs.	Months Days		in. 8. Date of Birth (Month, Day, Sept. 28	Year) Cour	lace (State or Foreign htry) nnsylvania
	Maryland a-f ehow	ctor	10a. State 10b. County Maryland Frederick		city, Town or Lo				. 1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 28	i Director	10e. Street and Number 7407 Willow Road			10f. Zip Code 2170	[1	Og. Citizen of What Cour	ntry?
980	be filed within 72 hours after death with the Maryland ital Hygiene. dig other then "natural", or Itams 23e or 28e-f ehow event, it e Medical Examination into the codified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	P. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cut		(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White, Specify:	etc.
21215-0036	within 72 ho lene. r then "natur tre Medical	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire ner & Ope	during most of i	working	16b. Kind of Business/In	dustry
Þ	m - 0 5	To Be C	17. Father's Name (First, Middle, Last) Harry Emerson Krone	2			18. Mother's N	Name <i>(First, Middle, I</i> Emma Steir	Maiden Sumame)	,,,
	nd 2 shoulth and 27 is mu		19a. Informant's Name/Relationship (Type Richard Creager / S						r, City or Town, State, Zip e, Maryland	
Baltimore,	. Pages 1 and 2 should be iment of Health and Menta tant: If item 27 Is marked jury or other treumatic ex		20a. Method of Disposition 14∑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	20b.	Place of Dispo cemetery, cres	sition (Name of matory or other place Cemete	ice)	Date	20c. Location - City or To	own, State
Balti	permit. Page Department Important: Il any injury o		21. Signature of Funeral Service Licensee	CHI!	R()	Name and Addr BERT E. 5 EAST M	ess of Facility DAILEY IAIN STR	& SON, FUNE	ERAL HOMES,	P.A. 88
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or compile shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it may be a support to the cause. Enter Underlying Cause (Disease or injury)	Due to (or as a conse	equence of):	er the mode of dy		adonator	0.01	Approximate Interval Between Onset and Death
Box 68760,	The law requires that the death certificate be executed to has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai	that initiated events resulting in death) Last d. IF FEMALE: 23b. Was decedent pregnant	Due to (or as a consection of pregent of the consection of pregent of the consection of pregent of the consection of pregent of the consection of the conse	nancy	Ectopic pregnanc			23d. Date of deliv	ery
o.	that the deat led by the attr detached for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown		Other (specify)	.,		Month	Day Year
ords, P.	w requires that been signed should be del	þ	Part II. Other significant conditions control	ributing to death but not re	sulting in the u	nderlying cause g	ven in Part I.	23e. Did tol	bacco use contribute to the	
of Vital Records,		Completed	- Hyperlips	domin				24a. Was a autops perform	sy prior to co	psy findings available mpletion of cause of
fVit	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA	her 1	Death <i>Check only on</i> g Home 5 \to Reside	ence 6 □Other <i>(Specii</i>	y)
Division o	grand and	Certification:	27. Manper of Death 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Spec	28b. Time o Injury	M 1 [Yes 2 No		ow injury occurred	ul Route Number,
Ö	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edicai Cert	29a. Certifier Check only 2 Medical Examin	cian: To the best of my ki	nowledge, deat	n occurred at the t	ime, date and pla opinion, death o	ace, and due to the c	ause(s) and manner as s	tated.
)	To the I within 2. To the I complet	Med	29b. Signature and title of certifler 30. Name and address of person who	and manner stated	ALL	29c. Licen	35/8		egd. Date signed (Month,	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 7 200	32 Pegistrar's Sign	26 3	300 U	105T 9	Th Green	reller	ick, mo

Ynow to Physician as! Fifth Cheroft

07-06878

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 30190

Charles L. Cassell			ate of Maryland	/ Departm	nent of cate of	Health a	nd Mentai	nygien	e Reg. I	21	10/ 3015
	Re	or State histrar Decedent's Name (First, Midd	lle Last)	Certific	Jale of	Dean		2. Date	of Death		3. Time of Death
Physician/ Me 'Examine			Lee Casse	11				Sep	ember 4	, 2007	1450 hrs
LXamino		. Facility Name (if not institution	on, give street and number	r)	4		or Location of D	eath		4c. County of Dea Frederick	tn .
		Rt. 144 and Quinn Or				Frederick		4Hrs 8 Da	te of Birth(I	MM/DD/YYYY) 9. E	irthplace (State or
Funeral	5.	Social Security Number		ige (In yrs, last b		Months D		Min		1Fore	country) Texas
Director	2	29-80-4340	1 X M 2 F.	. 55	Yrs.		15 4	Ju	1y 24	, 1952	G I
		sual Residence of Decedent a. State 10b. County	,	10c. City, Tow	vn or Locati	ion					10d. Inside City Limits
ow an	h.		ederick]	Mt. Aiı	сy		AL	L.	1 Yes 2 X No
ryland a-f sh		aryland Fre	Sucrick			10f. Zip Cod		1	10g	. Citizen of What Co	ountry?
or 28		4702 Caleb Wo	od Drive				21771			United S	States erican Indian, Black,
death with the Maryland or items 23a or 28a-f show must be notified at once.		1. Marital Status	12. Was Decede		13. Wa	es Decedent of	f Hispanic Drigin Iban, M exican, P	? (Specify Y uerto Rican,	es or No- etc.)	White, etc	
death r iten	Funeral	Never Married 2 X	1 Yes	2 X No			No specify:	Δ3		Specify:	White .
after	<u>~</u> -	Widowed 4 D 15. Decedent's Education (Sp	Divorced If Yes, Give Year or Dates:	completed) 16	a Deceder	ate Heural Occ	unation (Give kir	nd of work do	në 1	6b. Kind of Busines	ss/Industry
hours	e L	15. Decedent's Education (Sp. Elementary/Secondary (0-12			during m	nost of working	life. DO NOT us	se retired)	,,,	res and continued to the continued to th	Appropriate on Association of Association (Control of
36 tin 72 than "	<u>B</u>	Elemental y/occordary (* *-	3		Suj	perviso	or	. 10		U.S. Go	vernment
5-0036 iled within 7 Hygiene. 1 other than	Completed	7. Father's Name (First, Midd	le, Last)							aiden Surname)	
215 215 be file mtal H rked o	8	John Cassell			40h Mailin	a Address : (Street and Numb	lizabe	Route Numb	oray er, City or Town, S	ate; Zip Code).
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumarite event, the Medical Examiner must be notified at once	ို	9a. Informant's Name/Relatio		134 THE P	4702	Caleb	Wood Dr:	ive M	t. Ai	ry, Maryl	and 21771
MD nd 2 sho	-	Beth J. Casse	:11	20b. Pla	ce of Dispo	sition (Name	of cemetery,	Date		20c. Location - City	y or Town, State
altimore, mit Pages I an epartment of Hea portment of Hea programs: If itee		1 Burial 2 X Cremat	tion 3 Removal from			other place) Cremat	ory	Septem 7, 20	ber 07	Frederio	ck, Maryland
thent thent	1	Donation 5 Other Signa re of Funeral Servi	Specify:	Stat	22.	Name and Ad					mes, P.A. aryland 21771
Bal permi Depar Impo	- 1	[/(/0 /			8	E. Rid	lgeville	Blvd.	Mt.	Airy, Ma	Approximate Interval
Physician	+	23a. Part I. Enter th. ii. ase, failure. List only one cau	, or complications that cau	sed the death. D	o not enter	the mode of c	lying, such as ca	rdiac or resp	iratory arre	st, shock, or near	Between Onset and Death
Medical	1	Immediate Cause (Final disea	_{ase a.} Head and Ne				:,,				Bodu
_xaminer		or condition resulting in death	Due to (or as a co	onsequence of):			e 0,	. 3		7 7	
-1	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequence of):.			1		-		
	Examiner	cause. Enter Underlying Cau (Disease or injury that initiate	use c.								
st sd	Xa	events resulting in death) La	Due to (or as a c	consequence or).							
be executed sician and urial - transit	edical	UNPENDED	a								
O, ie be exi ysician burial	ledi	IF FEMALE:	23c. If yes, or	utcome of pregna	ancy					23d. Date of de	livery Day Year
Box 68760 e death certificate the attending physed for use as the b	sician/M	23b. Was decedent pregnant past 12 months?	in the 1 Live bir		2	Fetal death		pregnancy] Month	Day 100.
OX 6	sicia	1 Yes 2 No 9	7		5	Other (Special	·y)				
ords, P.O. Book warequires that the deas been signed by the strong the detached for the detached for the strong to be detached for strong to be detach	Phys	Part II. Dther significant co		death but not res	sulting in th	ne underlying o	ause given in Pa	art I.			ite to the cause of death?
P.O.	ğ										Probably 4 Unknown
ds, equire een stj	Completed								24a. Was auto	psy pri	ere autopsy findings available or to completion of cause of
COF law r thas b	mple								perto 1 ✓ Yes	ormed? de 2 No 1	ath? Yes 2 No
tal Rec		25. Was case referred to me	edical			2	6.Place of Death	(Check only	one)		
Vital F ysiciau: his certifi director,	Be	examiner?	Hospital:	npatient 2	ER/Outpati			Nursing H		Residence 6	
of Vital Records, ing Physician: The law require. After this certificate has been si uneral director, page 2 should t	2	27. Manner of Death	28a. Date of (Month) Sep 4, 2	of Injury Day Year)	28b. Time	,	8c. Injury at Wor	- lOr	d. Describe erator Di	how injury occurred f motorcycle in	motor vechile collision
ion of \ tending Phy eath. top: After the funeral	tion		rending		1444 hrs	-	1 Yes 2	253	Lacation	(Street and Number	or Rural Route Number, City
Division Division Septial or Attendit hours after death. meral Director: /	Certification:	3 Suicide 6	Could not be 28e. Place	e of Injury - At ho			office building, e				oad, Frederick, MD
Divisi ospital or At hours after d uneral Direct	Ser	4 Homicide		Major Road	-		time date and n	lees and die	o to the cal	see(s) and manner	as stated.
e Hos 124 ho e Fun		29a. Certifier 1 Certifyi	ing Physician: To the bes	st of my knowleds of examination a	ge, death o nd/or inves	ccurred at the tigation, in my	opinion, death o	ccurred at th	e time, dat	e and place, and du	e to the cause(s)
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funcal Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	one) 2 Medica 29b. Signature and title of c	and mainer 3	stated			: License numbe			29d. Date signe	d (Month, Day, Year)
	Σ	Zab' Signature and title of c	0 1/00	011	^		O.C.M.E.			September	5, 2007
_		30. Name and address of p	erson who completed call	se of death (Item	1 23a)					_!	
10		30. Name and address of p	Assistant Medical	Examiner	111 Per	nn Street, l	Baltimore, M	D 21201			
	State	1		eg trar's Signati	ure	hack	,				
Pagis			P 0 7 2007	Glave	J.	Sparke					

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Philip Alexander Clarke SEPTEMBER 12 2007 2:10 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's St. Mary's Hospital Leonardtown Birthplace (State or Foreign Country)
 Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) December 29,1920 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 86 219-16-2315 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 X Yes 2 □ No Director St. Mary's Leonardtown Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or USA 24205 Pin Cushion Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or itel Iny or other traumatic event, the Medical Examiner. 1 ☐ Yes 2 🗓
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify ð Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Philip Paul Clarke Mary Helen Norris ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44446 Clarksmill Road, Hollywood, Maryland 20636 Philip Warren Clarke / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H
Important: If iter
any injury or oth September 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Leonardtown, Maryland 4 Donation 5 Other (Specify) Charles Memorial Gardens 15, 2007 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Sign Jury of Funeral Service Licenses P.O. Box 270, Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each in Approximate Interval Betwee Onset and De e death. Do not enter the mode of dying, such as cardiac or respiratory arrest and Death Immediate Cause (Final Houte **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a so Examiner law requires that the death certificate be executed CHF physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9□Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an ,24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No has page certificate 2 No 1□ Yes 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manuar of Death 28a. Date of Injury 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 □ Yes 2 □ No 2 ☐ Accident I Director: Ad in by the f 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral t

completely filled 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d, Date signed (Month, Dav. Year) 29b. Signature and fitle of certifier D0062213 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SURESH PATEL, M.D. 22650 CEDAR LANE COURT, LEONARDTOWN, MARYLAND 20650 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

SEP 1 4 2087

ALEXANDER CLARKE

sion or Vital Records, P.O. Box 68760,	Baltimore, Maryland 21215-00:
tending Physician: The law requires that the death certificate be executed	permit. Pages 1 and 2 should be filed within 72 hours
tor: After this certificate has been signed by the attending physician and	Department of result and mental hygiene. Important: If item 27 is marked other than "natural"

		For State of Maryland / Department of the State Registrar Cer	rtificate of Death	nemai mygie Reg.	2007	30192
Physici	an	1. Decedent's Name (First, Middle, Last) Elizabeth C. Corasaniti		2. Date of Death Month	Day Year	3. Time of Death
/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		31 2007 4c. County of Death	1
	♠	105 S. Winchester Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Annapolis If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Anne Ar	
Funeral Director		213–26–3832 1 M 2 XF 80 Yrs.	Months Days Hours Min.	(Month, Day, Ye	ear) Cool 1927 Ma	nplace (State or Foreign untry) aryland
e Maryland a-f show tified at	ctor	Maryland Anne Arundel 10c. City, Town or Lo	Annapolis			10d. Inside City Limits 1 ☐ Yes 2XXX0
th with th 23a or 28 ust be no	Funeral Director	10e. Street and Number 105 S. Winchester Road	10f. Zip Code 21409	10g.	. Citizen of What Cou	-
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatly and Mental Hyglene. Important: I fire XT is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2XXII Specify:	pecify Yes <i>o</i> r N <i>o-</i> o Rican, etc.)	14. Race - Amer Black, White Specify:	
vithin 72 hone. han "natu e Medical	Completed	(Specify only highest grade completed) (Give life. I	tent's Usual Occupation kind of work done during most of work DO NOT use retired) Bookkeeper	king	b. Kind of Business/I	
d be filed v ental Hygie ced other t	To Be Co	17. Father's Name (First, Middle, Last) William Waitz	<u> </u>	ne (First, Middle, Mai		
ind 2 shoul alth and M 27 is marl er traumati	ř	19a. Informant's Name/Relationship (Type. Print) Michael F. Delea, Jr./executor 19b. Mailin 400 A	ng Address (Street and Number or Rus 11egheny Avenue	ral Route Number, Co Towson, Ma		ip Code) 21204
Pages 1 and the part: If item		20a. Method of Disposition 1XXBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Dispocemetery, cref. Most Holy	Redeemer Cem. 9/	6/2007 Ba	c.Location - City or T altimore,	Maryland
permit. Departr Imports any inju			2. Name and Address of Facility J. 7 Duke of Glouces	_	ylor Funer Annapolis,	
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition)	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of):				
cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
tificate be executed g physician and as the burial-transit	ledical Ex	resulting in death) Last Due to (or as a consequence of): d.				
The law requires that the death certificate has been signed by the attending place 2 should be detached for use as t	sician/N		Ectopic pregnancy		23d. Date of deli	very Day Year
quires that I n signed by	d by Phy	Part II Other significant conditions contributing to death out not resulting in the un	nderlying cause given in Part I.		cco use contribute to	the cause of death?
ate pag	Completed			24a. Was an autopsy performed	prior to c death?	topsy findings available ompletion of cause of 2 ☐ No
Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	Othor	th (Check only one)	a Flori	77.)
ding Phy h. After this funeral d	 	27. Manner of Death Natural 5 Pending (Month, Day Year) Accident investigation		28d. Describe how i	e 6 □Other (Specinjury occurred	ify)
al or Atter s after deal	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death one) Medical Examiner: On the basis of examination and/or invanid manners lated.	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
To t withi To tl	M	29b. Signature and title of certifier	29c. License number D 0 8 1		Date signed (Month	n, Day, Year)
w W		30. Name and address of person who completed cause of death (Item 23a) (Type, Dr. JACK LITTEN STEIN	Print) 205 Ridgely	, Ave	Annap	40/ 100
Sta Registr	_	31. Date filed (Month, Day, Year) SEP 0 5 2007	alles)			

State of Maryland / Department of Health and Mental Hygienes 30193 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Charles Theodore Dorsey 4:10 PM /Medical August 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Prince George's Hospital Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 2□F Days Hours 579-36-2615 76 Yrs. Director June 6, 1931 Washington, DC Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or Itema 23a or 28a-f show the Medical Examinat must be notified at 1 ☐Yes 2 ☐ No Director District of Columbia Washington the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4270 East Capitol Street, NE #201 20019 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 African 1 ☐ Yes 2 ☐ No Specify: þ Specify 3 ☐ Widowed 4 D Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 3 years Health Care Administrator Private marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be filt fment of Health and Mental Hy tant: If item 27 is marked oth jury or other traumatic event Be James Douglas Mary Dorsey 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Dorsey-Hockaday/Daughter 2102 Callaway St. Temple Hills, MD 20748 Important: If iten any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery | Sept 8, 2007 Suitland, MD 22. Name and Address of FacilityStewart Funeral Home, Inc. permit. 21. Smature of Funeral Sa Benning Road, NE Washington, DC 4001 23a. Part h Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one caus; in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of) Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 0.0 detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate 1 Yes 2 No 1 Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 1 🗌 Inpatient 2 P/Outpatient 3 DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. Diractor: After Certification: 5 Pending investigation 1 ANatural 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 24 within 2 To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Hem 23a) (Type, Print) 30. Name and address of perso . Taru 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 0 6 2007

			For State Registrar		State	of Maryla		artment of I rtificate of			_	giene	200	7	30194
	Physici		1. Decedent's Name		Last) Dave						2. Date of De Month SEPTE	ath		ůr Ö7	3. Time of Death 9:40 a ^M
•	/Medio		4a. Facility Name (I	f not institution,	give street and n	umber)		4b. City, Town, o		of Death		4c.	County of D	eath	
	Funeral Director		5. Social Security N	lumber 6	5. Sex 11 ☑ M 2 ☐ F	7. Age (In yr.	s, last birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bir (Month, Da 08/19/	rth ay, Year)	9. [Birthpla Count	ace (State or Foreign
	Maryland a-f show fied at	tor	Usual Residence of 10a. State Maryland	10b. County	v's		City, Town or Lo							10	d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the 3a or 28a st be not	al Director	10e. Street and Nui	mber				10f. Zip Code 20650				10g. Citi	izen of What	Count	y?
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Marr 3 Widowed	ied 2 ∏ Marrie	12. Was De Armed F	cedent Ever in orces? 2 No Sive	U.S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No			cify Yes or No lican, etc.)		14. Race - A Black, W	hite, e	
Baltimore, Maryland 21215-0036	within 72 hor ene. than "natur he Medical E	Completed	(Spec	, , ,	grade completed	(1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire Officer	pation during mos. d)	st of workin	g		ind of Busine	ss/Indi	istry
and 2	d be filed ental Hygiced of the code of th	Be	17. Father's Name Umedrai	•	Iast)		Bank	OTTICET		er's Name	(First, Middle	1			
Maryl	d 2 shoul th and Me 7 is mark traumati	2	19a. Informant's N	ame/Relationshi				ng Address (Street	and Numbe	er or Rural	Route Numb			-	,
nore, l	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai			position	3 □Removal from	20b	. Place of Dispo cemetery, cre	Paw Paw position (Name of matory or other pla ld-Echols	ice)	Da	ate	20c. Lo	ocation - City	or Tov	n, State
Baltii	permit. P Departm Importar any inju		21. Signature of Fu		Mruid	ella	d^2	2. Name and Addro 2. 1111	ess of Facilit	^{ty} Bri	nsfield	i Fur	neral 1	Hom	e, P.A.
•	Physician /Medical		23a. Part1. Enter t shock, or hea Immediate Cause (disease or condition resulting in death)	ırt failure. List o (Final	nly one cause on	caused the de each line.	ath. Do not en					arrest,	/	1	Approximate Interval Between Onset and Death
8760,	ate be executed away was invision and the burial-transit	al Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	5	c	o (or as a conse		7							MINUTES
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rds, P.O	quires that the de n signed by the a uld be detached t	1	Part II. Other signit		-		_						use contribute		cause of death?
DAVE Vital Records,	> 0 50	Completed by	(5	ZEBR	LOV KY	ILLA	2	- 1000	NT	_	24a. Was auto perfo 1 Yes		prior death	to com	sy findings available pletion of cause of
NDRA DA	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	To Be	25. Was case refer examiner? 1 Yes 2 27. Manner of Deat 1 Natural	No	28a. Date	Inpatient 24 of Injury	ER/Outpatie	nt 3 DOA Oth	ner: 4□ Nu	rsing Hom	(Check only only only only only only only only	idence	6 □Other (S	pecify)	
PRAVINCHANDRA Division or '	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investiga 6 Could no determin	t be 28e. Plac	ce of injury - At ding, etc. (Spec	home, farm, st	M 1	Yes 2□I		Bf. Location (City or To			Rural	Route Number,
A. B.	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one)	2 Medical E	xaminer: On the	ne best of my ki basis of exami nner stated.	nowledge, deat nation and/or ir	th occurred at the to	opinion, dea	nd place, a ath occurre	nd due to the d at the time,	cause(s) , date and) and manner d place, and o	as sta	ted. the cause(s)
	with To	2	29b. Signature and	Chri		>		29c. Licens	465	793		29d. Dat	te signed (Mo	onth, E	,
			30. Name and addr DR • 31. Date filed (Mon	ANIL K	SHAH SI	·	OC HOLL	YWOOD MD	2063	36					
	Sta Registr	-	SEP 1	3 2007	Bran	Hegistrar's Sig	freed								

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after Denastment of Health and Mental Hyriena	z - a	
	Phy /M	sicia edic	
* %	EXC	11111111	
Division or Vital Records, P.O. Box 68760,	Hospital or Attending Physician: The law requires that the death certificate be executed thems after cleath.	Funneral Director. After this certificate has been signed by the attending physician and	

		For State of Maryland / Department of Health 1 - State Registrar Certificate of Deal			2007	30195
Physicia	an	Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
/Medic	al	Margie Dell Dickenson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location		ugust 3	1, 2007 4c. County of Death	4:10 P M
Examin	er	South River Health & Rehab. Center Edgewater			Anne A	
Funeral Director		5. Social Security Number 226-24-1603 Usual Residence of Decedent 6. Sex 1 M 2X F Residence of Decedent	urs Min.	Date of Birth (Month, Day, Y	'ear) Cou	place (State or Foreign intry) ginia
Maryland t-f show fied at	tor	10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Edgewater				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
th with the 23a or 28a ist be not	Funeral Director	10e. Street and Number 10f. Zip Code 1805 Potomac Road 21037			Citizen of What Cou United Sta	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 1 □ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No Specify Cuban, Mex 1 □ Yes 2 □ No Specify Cuban, Mex 1 □ Yes 2 □ No Specify Cuban, Mex 1 □ Yes 2 □ No		fy Yes or No- can, etc.)	14. Race - Ameri Black, White Specify: Wh	
d within 72 hayiene. r than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during not life. DO NOT use retired) Homemaker	most of working	16	Sb. Kind of Business/II Home	ndustry
ould be filed Mental Hyg arked othe atic event,	To Be C		Mother's Name (F .zzie Os	First, Middle, Ma bourne	niden Surname)	
I and 2 sho Health and Im 27 is m her traum		19a. Informant's Name/Relationship (Type. Print) Eddie Lee Dickenson/Son 1805 Potomac Road 20b Blood of Disposition (Many of		water, N	Maryland 2	1037
t. Pages 1 rtment of h rtant: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Place of Disposition (Name of cemetery, crematory or other place) Ceorge Washington Cemetery 22. Name and Address of Fa	cy 09/05/	/2007 Ad		yland
permi Depa Impo		2973 Solomons	s Island	Rd. Ed	gewater, M	D 21037
Physician /Medical	9 3	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	2			Approximate Interval Between Onset and Death
Examiner	er	Sequentially list conditions, if any, leading to immediate Due to or as a consequence of): Due to or as a consequence of): Due to (or as a consequence of):	TOINT	DIS	EASE	
icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
rtificate be executed by physician and as the burial-transit	edical	d				
ath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mortfis? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown			23d. Date of deliv	/ery Day Year
w requires that the described signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	Part I.	23e. Did tobad	cco use contribute to	
	Completed			24a. Was an autopsy performe 1□ Yes 2	prior to co	opsy findings available ompletion of cause of
sician certifi rector	o Be	examiner: Hospital: Other:	Place of Death (
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	-	27. Manner of Death The state of Injury 28b. Time of Injury	280	d. Describe how	ce 6 □Other (Spec	ny)
ital or Atters as after der ral Directo	Certification:	3 ☐ Sulcide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	281	f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
the Hosp in 24 hou the Fune npletely fil	Medical	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurr	n, death occurred	at the time, date	e and place, and due	to the cause(s)
Viti	2	29b. Signature and title of certifier 29c. Idense numb 29c. Idense numb	3/3	29d	I. Date signed (Month	, ∪ay, Year)
O CMH		30 Name and address of person who completed cause of geath (Item 23a) (Type, Print) 31. Date filed (Montical an Year) - 32. Pajistrar's Signature.	ave	Ballar	ine	md 2120
Sta Registr		31. Date filed (Monti SEP Year) 5 2007 32. Fluistrar's Signature				
MH 17 Rev 1/20	001					

07-06744 Joshua W. Dale Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 30196

		1- For State Registrar	C	Pertificate	of Death		R	eg. No.	
Physici		1. Decedent's Name (First, Middle,La	ast)				2. Date of Dea Month		3. Time of Death
/ledical Exam	iner	OODIIGG II. Daic					August 30), 2007	1740 hrs
		4a. Facility Name (if not institution, g Baltimore Washington M			4b. City, Town, o	or Location of Dea ie		4c. County of Anne Arur	
Funeral Director		217-08-3120	Sex 7. Age (In yr X M 2 F 27	rs. last birthday) Y	If Under 1 Ye Months Da]F	9. Birthplace (State or Foreign Washington Country) D.C.
any		Usual Residence of Decedent 10a. State 10b. County	100.0	City, Town or Loc	eation				I dod Incide City Linette
*	tor	Maryland Anne A			Davidso	nville	TAIL .		10d. Inside City Limits 1 Yes 2 X No
h the Maryland 3a or 28a-f sho	Director	10e. Street and Number 991 Wayson Way			10f. Zip Code 21035		1	0g. Citizen of What	: Country?
after death with the Maryland al", or items 23a or 28a-f sho iner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Marrie	1 Yes 2 X No	If	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (s an, Mexican, Puer	Specify Yes or No to Rican, etc.)		
s after iral",	ò		d If Yes, Give Year or Dates:	1_	Yes 2 X N			Specify:	White
, MD 21215-0036 and 2 should be filed within 72 hours ealth and Mental Hygiene. tem 27 is marked other than "natur traumatic event, the Medical Exam	Completed	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)	during	ent's Usual Occupa most of working life	e. DO NOT use re	f work done etired).	16b. Kind of Busin	
21215-0036 21215-0036 and be filed within 7 Mental Hygiene, marked other than	Som	17. Father's Name (First, Middle, Las	2 yrs.		Carpenter	18 Mother's Nam	ne (First, Middle, I	Carpen	try
21215 21215 wild be file Mental H marked c	Be	William P.	Dale				Carol Si	,	
21 hould nd Me is ma atic ev	٢	19a. Informant's Name/Relationship (, , ,	19b. Maili	ing Address (Stre			nber, City or Town,	State, Zip Code)
ore, MD set 1 and 2 show of Health and If item 27 is ther traumatiful.	-	William P. Dale, 20a. Method of Disposition		991	Wayson W	ay, Davi		e, MD 210	
5 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -		1 Burial 2 X Cremation 3 4 Domation 5 Other Specific	Removal from State	crematory or	osition (Name of co other place) rematory	*	Date 1/2007	20c. Location - C Edgewate	, ,
Baltimo permit. Page Department of Important: injury or oth		21. Signatur of Funeral Jen ce Live		22.	Name and Addres	ss of Facility Ge	orge P.	Kalas Fur	neral Home
Physician		23a. Part I. Enter the disease, or com	plications that caused the der	ath. Do not enter	the mode of dving	OMONS IS	Land Kd.	Edgewate	er, MD 21037 Approximate Interval
/Medical caminer	1 1	failure. List only one cause on e	each line. Chest Injuries		, ,		7	say shooty of floury	Between Onset and Death
, animo		or condition resulting in death)	Due to (or as a consequence	e of):					
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence	e of):		179	Tra t		
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):					- 1
recuted n and r transit									
760, icate be ex physician the burial	/Medical	UNPENDED	AMENDED						:
18760, rifficate be ing physic as the buri	M/u	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pr		etal death 3	Ectopic pregn	iancy	23d. Date of de Month	elivery Day Year
that the death certifued by the attending detached for use as	sician	past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant at time of	dooth	Other (Specify)				Say Noo.
O. Bont the decided by the	Phy	Part II. Other significant conditions	9 Unknown	ot resulting in the	underlying cause	given in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
res that signed I be deta	d by						1 Yes	2 V No 3	Probably 4 Unknown
Records, The law require ficate has been si	Completed						24a. Was a		re autopsy findings available or to completion of cause of
Record The language 2	mo:						perfor	med? dea	
tal Rec cian: The certificate ector, page	Be	25. Was case referred to medical examiner?	Hamilal		26.Place	e of Death (Check	only one)		
of Vital ig Physician: ther this certi	욘	1 ✓ Yes 2 No 27. Manner of Death		✓ ER/Outpatier					Other:
	ertification:	1 Natural 5 Pending 2 Accident Investigat	28a. Date of Injury (Month, Day Year) Aug 30, 2007	28b. Time of 1652 hrs		ury at Work? Yes 2 ✔ No		now injury occurred auto collision	
Division spital or Attendin ours after death.	ertific	3 Suicide 6 Could not determine	be 28e. Place of Injury - At		eet, factory, office I	building, etc.	or Town, S	Street and Number of tate) & Florida Ave, S	or Rural Route Number, City evern, MD
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier 1 Certifying Physic one) 2 Medical Examine	rian: To the best of my knowled r: On the basis of examination and manner stated.	edge, death occu and/or investiga	urred at the time, d ation, in my opinior	ate and place, and	d due to the cause at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
F % F 8	ğ	29b. Signature and title of certifier	7		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
		() autor	end		O.C.	M.E.		August 31, 20	007
304		36 Name and address of person who Laron Locke MD. Assis	completed cause of death (Ite stant Medical Examiner	,	n Street, Baltir	more, MD 212	201		
St Regist		31. Date filed (Month, Day, Year) SFP 0.5.2	32. Redistrar's Signa		Land :				
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ORIGINAL

07-07115 Eric Ellison Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 30197

		1- For State Registrar		Certifi	icate of L	Death			Reg. No	i				
Physicia		Decedent's Name (First, Middle,La	ast)					2. Date		Year	3. Time of Death			
edical Exami			Eric B.	Elli	son			Sept	Day ember 12	, 2007	1721 hrs			
		4a. Facility Name (if not institution, g		DIII		. City, Town, or	Location of De			c. County of Dear	th			
		Johns Hopkins Hospital				Baltimore			(District	VED 2000 A B	itheless (State or			
Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last l	birthday)	If Under 1 Year Months Days		1.6.	,	Fore	irthplace (State or ign			
Director			X M 2 F	2	25 Yrs.	MOTHETS Days	Hours	Jar	nuary	19,1982	puntryMaryland			
· · · · · · · · · · · · · · · · · · ·		Usual Residence of Decedent 10a. State 10b. County	T.	10c. City. Tov	wn or Location	n					10d. Inside City Limits			
rith the Maryland 5, 23a or 28a-f show any 2, notified at once.	_	Maryland	-			Baltin	ore	12			1 X Yes 2 No			
aryla 8a-f	당	10e. Street and Number				10f. Zip Code			10g. C	tizen of What Co	untry?			
ne M or 2 fred	Director	2003	Overland	7		2	1214		U	.S.A.				
ith (1		11. Marital Status	12. Was Decedent B		13. Was	Decedent of His		(Specify Ye			erican Indian, Black,			
ath w	Funeral	1 Never Married 2 X Marri	ed Armed Forces?		If Yes	s, specify Cuban	, Mexican, Pu	uerto Rican, e	etc.)	White, etc.	171			
er de			1 Yes 2 ed If Yes, Give Year	X No	1 1	Yes 🗶 No	specify:			Specify:Whi	te			
s'aff	۵.	15. Decedent's Education (Specify	or Dates:	nleted) 16		s Usual Occupat		d of work don	e 16b	. Kind of Business				
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exam	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	,		st of working life				Service Services	1.			
36 in 72 han lical	읦		James (1 1 and	·	Di	sabled								
5-0036 ed within 7. tygiene. other than the Medical	틍	10 17. Father's Name (First, Middle, La	et)					Name (First, N	Aiddle, Maide	en Surname)				
15- filed Hygel of	Ö	17. Fattler S Name (First, Middle, La	 William	Ellie	on			sa Öcc						
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	o B	19a. Informant's Name/Relationship				Address (Stree				City or Town, Sta	ite, Zip Code)			
C ch b s is	F			100										
e, MD t and 2 sho Health and item 27 is		Jessica A. Be	rkley-brr	20h Pla	ce of Disposit	tion (Name of ce	metery.	Date	Ball 200	LINOTE . (1)	or Town, State			
TOFE, ages I a nt of He t: If ite		1 Burial 2 X Cremation			matory or other				,					
Page Page nent c			·F	Bavv	riew C	remato	ry 9	-22-0	7 E	<u>Baltimo</u>	re,Maryland			
Baltimore, bermit Pages I ar Department of He Important: If ite		21. Signature of Funeral Service Lic	ensee		22. Na	ame and Address	s of Facility	arzul	lo Fi	neral	Chapel P A			
E P P E		21. Signature of Funeral Service Lice 22. Signature of Funeral Service Lice 23. Part I. Enter the disease, or co	rello		60	09 Har	ford	Road	Balti	more.M	aryland2121			
Physician		23a. Part I. Enter the disease, or co	mplications that caused	the death. D	o not enter the	e mode of dying	such as card	diac or respira	atory arrest, s	hock, or heart	Approximate Interval Between Onset and			
/Medical		failure. List only one cause on		th compli	cations .					r	Death			
.xaminer		or condition resulting in death)	Immediate Cause (Final disease a Head Injuries with complications											
		Sequentially list conditions,	b											
	ē	if any, leading to immediate												
	늍	cause. Enter Underlying Cause (Disease or injury that initiated	c					* 0						
1 8 . E. C.	Examiner	events resulting in death) Last	Due to (or as a conse	equence or):										
executed ian and ial - transit			d					-						
760, icate be execut physician and the burial - tra	/Medical	UNPENDED	AMENDED											
760, ficate be g physic the bur	Ĭ	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome		ncy		Ectopic p	**************************************		23d. Date of deliv Month	ery Day Year			
68 certif ding	ia	past 12 months?	1 Live birth 4 Pregnant at	time of death			Lotopic p	леднаноу	1	World	50)			
P.O. Box 687: that the death certifine ned by the attending detached for use as t	siciar	1 Yes 2 No 9 Unkno			5 Otr	ner (Specify)								
the d	Phy	Part II. Other significant condition	ns contributing to deat	h but not resi	ulting in the u	nderlying cause	given in Part	I. 23	Be. Did tobac	co use contribute	to the cause of death?			
ords, P.O. w requires that the state of the	<u>۾</u>								Yes 2	. ✓ No 3 F	Probably 4 Unknown			
S, quires an signal d bo	Completed							1 24	4a. Was an		autopsy findings available			
COFC law re has be	음								autopsy performed		to completion of cause of			
Che la	E	1						1 9		No 1 🗸	Yes 2 No			
/ital Rec	0	25. Was case referred to medical				26.Plac		Check only on	e)					
Vita hysicia this ce I direc	e Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2 E	R/Outpatient	3 DOA	Other ₄	Nursing Home	e 5 Res	sidence 6 O	ther:			
ion of Vital Records, P.O. Box 68760, trending Physician: The law requires that the death certificate be leath. for: After this certificate has been signed by the attending physici the funeral director, page 2 should be detached for use as the burit	-	27. Manner of Death	28a. Date of Inju		28b. Time of Ir	njury 28c. Inj	ury at Work?			injury occurred ick by auto				
ion tendim eath. tor: A	<u> </u>	1 Natural 5 Pendir		(0000 hrs	1	Yes 2 🗸 N	No Fede	Sulan Suc	ick by auto				
	<u>S</u>	2 🗸 Accident Investi	28e Place of tr	njury - At hom	ne, farm, stree	et, factory, office	building, etc.				Rural Route Number, City			
Div alor al Dia	24a. Was an autopsy performed? 1									Road, Baltimo	re, MD			
ie ou	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as										stated.			
To the Hos within 24 h To the Fur	edical	(Check only one) 2 Medical Exam	iner:On the basis of exa	mination and	d/or investigat	tion, in my opinic	n, death occu	urred at the ti	me, date and	place, and due to	o the cause(s)			
To the within 2 To the complet	<u>6</u>		and manner stated.				ise number				Month, Day, Year)			
	Σ	23b. Signature and title of certifier					.M.E.		1	September 14				
		med 2									,			
•		30. Name and address of person v			23a)	N		24004						
/		Ana Rubio MD. Assis				Street, Baltim	nore, MD 2	2 1201						
	State	31. Date filed (Month, Day, Year)		ar's Signature	e ADGA	Es)								
	stra	SEP 2.0 2	2007 DEFERRA	A Feb	A STATE OF THE STA	43								

			1 - For State Registrar	State of Maryla		rtificate of L			eg. No.	30198		
P	Physici	an	1. Decedent's Name (First, Middle, La Douglas Eugene E					2. Date of Death Month	Day Year	3. Time of Death		
	/Medic		4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death		r 8, 2007 4c. County of Death	11:05 A [™]		
			Southern Maryland	Hospital Cen	ter	Clin	iton		Prince Ge	eorges		
	Funeral Director		5. Social Security Number 6. S 220-40-4764	Sex 7. Age (In yr. X M 2 F 64	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)		
las.	D		Usual Residence of Decedent					August 10	0, 1948 Vii	ginia		
	arylan show	'n	10a. State 10b. County Maryland Charle		City, Town or Lo Waldorf					10d. Inside City Limits 1 ☐ Yes 2 No		
	the M	recto	10e. Street and Number	5	WGIGOII	10f. Zip Code		10	g. Citizen of What Cou			
	th with 23a or ust be	al D	15151 Prescott C	t.		20601			USA			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 □ No	spanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Wh Specify:			
15-(n 72 h "natu edlcal	lete	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor	king 1	6b. Kind of Business/I	ndustry		
212	d withingiene.	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	Sheet	Metal Wo	rker		Sheet Meta	1		
nd	be filed tal Hyg d othe event,	Bec	17. Father's Name (First, Middle, Last,					ne (First, Middle, M	,			
Maryland	hould d Men marke matic	은	Thomas E. Ellin	Thomas E. Ellinger Martha E. Buzzard 9a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
	and 2 salth an 27 is		Lola M. Ellinger/			51 Presco				ρ Code)		
Baltimore,	Pages 1 and of He		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			osition (Name of matory or other place emorial G		ember	Oc. Location - City or T	,		
Balti	permit. Departi Importi any inj		21. Signature of Funeral Service Licer		22	2. Name and Addres	ss of Facility \mathtt{Bri}	nsfield-H	Echols F.H. Lotte Hall,	, P.A.,		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only		Approximate Interval Between							
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Acute	Meni	190-CD	cebba	11+15		Onset and Death		
				Due to (or as a conse	equence of):	die A	ne min	5				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ally list conditions, diding to immediate Due to (or as a consequence of): nter Underlying								
	xecuter and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	editable of).							
68760,	tificate be executed g physician and as the burial-transit	calE	(ed.								
89	artificat ng phy e as th	Medical	IF FEMALE:						11			
Box	he death cert the attending	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of deliv Month	very Day Year		
P.0	at the I by the	hys	9 🗆 Unknown	9□Unknown								
Records,	The law requires that the death certificate be executed te has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions of	ontributing to death but not re	Sulting in the u	nderlying cause give	en in Part I.		acco use contribute to s 2 □ No 3 □ Pro	. /		
Seco	e law re as be	Completed	Hypono	atremia!				24a. Was an autopsy		opsy findings available ompletion of cause of		
			/ / / / / / / / / / / / / / / / / / /					autopsy perform 1□ Yes 2	death? ☐No 1☐Yes	2 No		
r Vital	> .97	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Othe	MT.	th <i>(Check only one</i>	nce 6 Other (Speci	(6z)		
	क ≑ क		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury			28d. Describe how				
Division	ten eath tor:	icatio	2 Accident Investigation 3 Suicide 6 Could not be		home farm etr		/es 2□No	20f Looption (Ctr	and Alexandre and Dec	The state of the s		
Ο̈́	al or A s after al Direct	Certification:	4 ☐ Homicide determined	building, etc. (Spec	cify)	eet, lactory, office		City or Town,	eet and Number or Rur State)	аг поше митрег,		
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical C	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, death	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)		
	To the within To the Comp	Me	29b. Signature and title of certifler	Aun .		29c. License			d. Date signed (Month,			
13) m		1 / Just / /	MD			2200)	9, 10,20	10.4		
10	N)		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type,	Print)						
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature		<u> </u>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland, Department of Health and Mental Hygien Part State Amended 23a per phys, DOR, 9/18/07, LDB Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ell: ott Month Day **Physician** 46 September 2 2007 eroy vanc /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Huspital ambridge Dorchester Dorchester General If Under & Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 220-26-9101 1**☑**M 2□F 76 Months Days May 15, 1931 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified. 1 Yes 2 No Director Dorchester 10e. Street and Number 10f. Zip Cou 10g. Citizen of What Country? eachblossom 2/61 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No / 9 5 3 If Yes, Give Year or Dates: / 9 5 5 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2□No 1953 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced 1955 Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Kena 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) achblossom Ave. Cambridge, MD. 21613 inda 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/0 Huylock, MD. 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home, P. A. 516 Washington St. Cambri 10 Washington St. Cambridge, MD. 21613 23a. Papil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician yocardial Intarction 24 hours disease or condition resulting in death) /Medical Due to (or as a consequence of) days Examiner Devere if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) burial-transit and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Month Year signed by the at d be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient £ 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 13238 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 X. Campridge Gramble 31. Date filed (Mong. Pay gistrar's Signature State 2007 Registrar

		Physic /Medi Exami	cal
40.		uneral irector	
	ne Maryland	8a-f show otified at	ector

			1 - State Registrar Ce	rtificate of		Re	eg. No. 2007	30200
	Physici		1. Decedent's Name (First, Middle, Last) Mary Elizabeth Emmart			2. Date of Death Month	Day Year er 8, 2007	3. Time of Death 12:55 P M
	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	r Location of Death	ъерсешь	4c. County of Deatl	
	ii.		St. Mary's Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Leo	nardtown	0 D-4 (Di-4-	St. Ma	
30.	Funeral Director		216-24-7973 1 M 2 M F 78 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, November	Year) 9. Birth Con 20, 1928 Ma	nplace (State or Foreign untry) uryland
	he Maryland 8a-f show otified at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland St. Mary's	Mecha	nicsville			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 2 ust be no	al Dire	10e. Street and Number 27575 Brothers Lane	10f. Zip Code	20659	10	og. Citizen of What Co USA	untry?
5-0036	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☑ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
215-(thin 72 h e. an "natu Medi a	Completed	(Specify only highest grade completed) (Give life.		ation during most of worki d)	ing	16b. Kind of Business/I	·
2121	led with the the the the the the the the the t	Co	12 Home	emaker	do Marke de Meser	/F:	Own H	ome
Maryland	0 = 0 \$	To Be	Raymond Golderman		18. Mother's Name		Golderman	
ary	2 shou and M is mar aumati	+	19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ng Address (Street			City or Town, State, Z	ip Code)
≦ aî	l and 2 lealth m 27 i		TITCHACT RAYMONA BIRMATE / BOIL	Emmart Lan		csville, M		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic e		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Dispocemetery, cre Most HO1y I Cemetery	matory or other plac	1 (00	ther 12	20c.Location - City or T Baltimore, Ma	
Balt	permit. Departi Importa any Inji		21. Signature of Funeral Service Licensee 22.		ss of Facility -Gardiner Fu 70 Leonard			
	Physician /Medical Examiner	Examiner	23a. Pat 1. Enter the disease, or complication—that caused the death. Do not enter shirts, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):					Approximate Interval Between Onset and Death
. Box 68760	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Medical E		Ectopic pregnancy Other (specify)	,		23d. Date of deliment	very Day Year
7. O	at the did by the stached	Physi	9 ☐ Unknown					
ecords,	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause giv	en in Part I.		acco use contribute to s 2 ☑ No 3 ☐ Pro	the cause of death? bably 4 Unknown
r		Completed	S/P Caralisal Thumbosos: I	Deman	tia	24a. Was an autopsy perform 1 Yes 2	prior to c	opsy findings available ompletion of cause of
VItal	Physician: r this certifica ral director, I	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier	ot 3 DOA Othe	26. Place of Death			~ .
on or	nding Phy th. : After thi s funeral o		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year) 1 Accident Investigation	f 28c. Injur Worl		28d. Describe how	nce 6 Other (Spec w injury occurred	iry)
Division	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)	eet, factory, office	2	28f. Location (Str. City or Town,	eet and Number or Rui State)	ral Route Number,
	he Hospit n 24 hour he Funera	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deatted the properties of examination and/or in and manner stated.	h occurred at the tir vestigation, in my o	ne, date and place, a pinion, death occurr	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
)	To the To the Congression of the	Me	29b. Signature and tile of certifier	29c. License	number 06419	29	d. Date signed (Month	, Day, Year)
			30. Name and address of person who completed cause of death (Hem 23a) (Type, 24035 Three Notch Road Hollywood,	Print) James MD 20636	P. Jarbo	e, M.D.	V 0	/
H	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature					

State of Maryland / Department of Health and Mental Hygienes 30201 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Gerald A Graham September 13 2007 3:37 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick 8. Date of Birth (Month, Day, Year)
Oct. 19, 1919 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Funeral Days Months Min. 1**⊠**M 2□F Hours 87 Director 215-14-1836 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location show r 28a-f show 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 200 Chapel Court, Apt. 102 Funeral 21793 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) n and Mental Hygiene. College (1-4or 5+) custodian public school 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ ပ Norman Graham Cora Kump 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 200 Chapel Ct., #102 Isabelle Graham/ wife Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mountain View Cem. 9/17/2007 Union Bridge, MD 21. Signal e of Funeral Service Lig 22. Name and Address of Facility Hartzler Funeral Home atharine (6 E. Broadway Union Bridge, MD 21791 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LANA Waniel **Physician** disease or condition resulting in death) HOURS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed attending physician and for use as the buriaf-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23h. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by u hih denin 1 → es 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1□ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Impatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D0062223 16/07 Name and address of person who completed cause of death (Item 23a) (Type, Print) , 196 TJ DRIVE, FREDERICK, MD 21402 PRAYEEN BOLARUM, TO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 130

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September™4, 2007 **Physician** Ellen. Elizabeth Gibson 9:50а м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Nursing Center Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Jun 2, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days 213-14-8202 1 □ M 2 X F Mary Land 85 Director Usual Residence of Decedent purmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural" --- any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Adamstown 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5325 Mountville Road 21710 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: White 2 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamer Manufacturing Company 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Frank Freed Sr Ellen Elizabeth Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Grable, Step-daughter 2910 Russell Avenue, Adamstown, Maryland 21710 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Olivet Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sep 18, 2007 Frederick, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Ford P.A. Funeral Home 21. Signature of Euneral Service Lice 106 East Church St, Frederick, Maryland 21701 MO0706 Part1. Enter the Asease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mummine /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. List Urbanking Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify)

been signed by the attending physician and should be detached for use as the burial-tran I or Attending Physician: after death. Director: After this certifica funeral

Completed by

Be

Certification:

25. Was case referred to medical examiner?

1 ☐ Yes 21 No

27. Manner of Death

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

Natural

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital:

28a. Date of Injury (Month, Day

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and

28b. Time of

23e. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown

24a. Was an 1∐ Yes

Injur Worl

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

26. Pla	ice of Death (C	neck only one)	
Other:	Nursing Home	5 Residence	6 □Other (Specify)
Injury at Work?	28d.	Describe how inj	ury occurred
1 ☐ Yes 2	□No		

autopsy

28f. Location (Street and Number or Rural Route Number, City or Town, State)

olace	e, an	d due	e to th	е са	use	(s)	and m	anne	ras	stated	ı.	
OCCL	ırred	at th	e tim	e, da	ate a	and	place	, and	due	to the	cause	e(s)

one)		and manner stated.		gation, in my opinion, death
29b. Signature an	d title of certifier	1011	ALL.	29c. License number

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υ.	Name	and	adur	ess or	person wh	o con	pletea	cause	or death	i (Item 23	a) (Type	, Print)
	15	1		7	7/	1/	7/		/ ~/		-	0 -

5 ☐ Pending investigation

6 ☐ Could not be

determined

Registrar DHMH 17 Rev 1/2001

State

within 24 hours a

ASTATE of Manhaha Department of Health and Mental Hygiene 17 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Gabriel Samira September 16, 2007 7:00 am^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Citizens Nursing & Rehab Center Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 1, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country)
 Lgypt **Funeral** 1 □ M 2X F 166-64-0683 84 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or Iteme 23a or 28a-f show other traumatic svent, the Madical Examinar must be notified at 10d. Inside City Limits Frederick Maryland Frederick Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1900 Rosemont Avenue 21702 U.S.A. death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "naturel", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Egyptian 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Iskander Kladious Mary Abdelnoor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 Is Mona Melhem, Daughter 113 Wesport Drive, Pittsburgh PA 15238 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Columbia Memorial Park Sep 16, 2007 Clarksville, Marylan permit, Page Department of Important: If any injury of • 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home MOO706 106 East Church St, Frederick, MD 21701

23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final congestive heart Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit anding physician and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery atten for u 3 Ectopic pregnancy Month 4☐ Pregnant at time of death 5 Other (specify) ed by the a ☐Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2**X** No 1 Yes 2 No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident atter death in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours att To the Funeral Di completely tilled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DQ055061 deplember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

SEP 2 0 2007

DHMH 17 Rev 1/2001

Aubrie Nagy, M.D., 300 West Ninth Street, Frederick, Maryland 21701
31. Date filed (Month, Day, Year)

Registrar's Signature

07-06833 Jamari Greenwell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 30204

			- For State legistrar					Certific	cate of	Death					Reg. N	0.			
Pł	hysicia		Decedent's Name (F	irst, Middl	t, Middle,Last) Greenwell Greenwell 2. Date of Death Month Day September 3, 2007 3. Time of Death 0049 hrs														
edical I			Jaman	i		Gr	eenwe	e11				3		Septem					49 hrs
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			Prince George	es Hosp	tal Ce	enter				Cheve						_		(State or	
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D 21215-0036 should be filed within 72 hours after death with the Maryland	Mental Hygiene. marked other than "natural", c event, the Medic I Examing:	ادہ	John W.			nn						Chant	v G	reenw	e11				
712 de be	Menta nark even	മി	19a. Informant's Nam						19b. Mailing	Address						, City or Tow	vn, Sta	te, Zip C	ode)
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	of Health ar If item 27 her traum		20a. Method of Dispo	sition				20b. Place	e of Dispos	ition (Nam	ne of cem	etery,		Date	20	c. Location	- City o	or Town,	State
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Division of Vital Records,	After th		27. Manner of Death			28a. Da	ate of Injur onth Day Ye 3, 2007	ry 28 ear) n	8b. Time of 015 hrs	Injury		ry at Work Yes 2 ✔	,	Passen	ger a	uto fixed	objec	t collis	ion and
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	ours a	Certification:	4 Homicide		termine	1.1-6		al Street					_		_				erry, wid.
Ξ.	c Fur letely		29a. Certifier (Check only one)	Certifying	Physic	ian: To the t	best of my	/ knowledge, nination and/	death occu	urred at the	e ti me, d a v opinion	ate and pla n. death oc	ace, and curred a	I due to the at the time,	cause(date ar	s) and mann id place, and	ier as s d due to	stated. o the cal	use(s)
To th	within 24 hours after death, with the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	edical				and manne	er stated.	aioir aiid/				e number		,		29d. Date sig			
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12			Margarita Ko					Examiner		enn St	ueel, B	aitimore	J, IVID	2 12U I					
	S	State	31. Date filed (Mont	t This	f)	Ag 32.	Registra	r's Signature	wer.										

Certificate of Death

30205

Year

29d. Date signed (Month, Day, Year)

5, 2007

September

Reg. 12 0 0 7

2. Date of Death

State Registrar

29b. Signature and title of certifier

Kirti Vohra, M.D.; 7710 Bradley Boulevard; Bethesda, Maryland 20817 32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D-20274

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Registrar Registrar 30206 Reg. No 2 U U 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Sept 3:20 PM 4a. Facility Name (If not institution, give street and number) va /Medical 2007 02 4b. City, Town, or Location of Death 4c. County of Death **Examiner** County Columbia Howard Howard (neneral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 9, 19 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Days Months 1 M 2 D F 1909 Director 98 577-32-2370 Canada Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Howard Dayton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4201 Linthicum Road USA 21036 Funeral Howard. Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 TYes 2∏ No Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) it item 27 is marked other than or other traumatic event. The Man Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse **Healthcare** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Wells Margaret Gallinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Strahle, POA 15402 Clayborn Drive, Laurel, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation X 5 ☐ Other (Specify) Chesapeake Crematory 9/6/07 Beltsville, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Going Home Cremation Service PO Box 784 4 euro M01251 Beverly L. Heckrotte, P.P. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician espiration SOMOUC week /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Divi to for as a nonsequence off The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 4☐Pregnant at time of death 9☐Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an tate has autopsy performed? Yes 2 No certificate 1 To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 100 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation ours after death.

neral Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certi-29c. License number 29d. Date signed (Month, Day, Year) D58747 4 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (1) 62

DHMH 17 Rev 1/2001

State Registrar Kandal

31. Date filed (Month, Day, Year)

Riesen MD

SEP 0 6 2007

32. Registrar's Signature

10700 Charter Dr. Columbia

The content of the	amela J. Gres		1- For State Registrar		epartment of Certificate of			Reg	g. No.	7 3020
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The Street and Number 150, Children 150, C			470 66 1217	E /		Months Days	 		1053 For	Birthplace (State or eign Minnesota Country)
Mary Land Treederick Tree	ny.	<u>.</u>		10c. (City, Town or Locat	tion		1		10d. Inside City Limits
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Carl Halon Doreen Hagg Informatic NameRelationship (Type, Print) Jordan Gresczyk/Son Jorda									16b. Kind of Busine	ss/Industry
Carl Halon Doreen Hagg Informatic NameRelationship (Type, Print) Jordan Gresczyk/Son Jorda	36 hin 72 e. than "1	plet		College (1-4 or 5+)				4	Retail	Resource
20. Hance of Disposition (Name of cemetery, crematory or office place) 20. Cocation - City or Town, State	5-00 led with Hygien other							(First, Middle, M	aiden Surname)	
20. Hance of Disposition (Name of cemetery, crematory or office place) 20. Cocation - City or Town, State	121 121 Idibe fi Aental J					a Address (Street		•		ato Zin Codo)
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Physician (Medical Team) Team) Team of the Use of the Contribution of the Contributi	Bal permi Depar Impo		21. Signature of Funeral Service Licen	see	16	21 Opossu	mtown Sta	uffer Fre	uneral Hoderick, M	m <u>£1782</u>
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Sequentially list conditions, if any, leading to immediate cause. Enter third lying Cause contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			Immediate Cause (Final disease a.	Chest and Abdomina	al Injuries					Death
If any, leading to immediate consequence of):				Due to (or as a consequent	ce or).		· .			
Company of the past of the past 12 months? Company of the past		niner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequen-	ce of):					
Was decedent pregnant in the past 12 months? The past 12 months? 1	outed nd ransit	I Exan	events resulting in death) Last	Due to (or as a consequen	ce of):					
Was decedent pregnant in the past 12 months? The past 12 months? 1	D, be exec sician a	dica								_
25. Was case referred to medical examiner? 1	ox 68760 ath certificate attending phy:	sician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of	2 F6		Ectopic pregnar	ncy	200. 2010 0. 00	,
25. Was case referred to medical examiner? 1	D. B. I the de by the	Phy		9 Olikilowii	not resulting in the	underlying cause giv	ven in Part I.	23e. Did tol	pacco use contribute	to the cause of death?
25. Was case referred to medical examiner? 1	ires that signed be deti	d by						1 Yes	2 🗸 No 3 📑 F	Probably 4 Unknown
25. Was case referred to medical examiner? 1	ords w requisit should	plete						autops	sy prior	to completion of cause of
25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only one) 26. Place of Death (Check only one) 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 28. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Driver struck a tree 28d. Describe how injury occurred Driver struck a tree 28d. Location (Street and Number or Rural Route Number or Town, State) NB Willowbrook Road, Frederick, MD		Com						1 ✓ Yes 2		
Sep 2, 2007 to 1 Yes 2 No Driver struck a tree Sep 2, 2007 to 1 Yes 2 No No Natural 2 No No Natural 3 Suicide Sep 2, 2007 to 1 Yes 2 No No Natural 2 No No Natural 3 Suicide Sep 2, 2007 to 1 Yes 2 No No Natural 2 No No Natural 3 Suicide Sep 2, 2007 to 1 Yes 2 No No Natural 2 No No Natural 3 Natural 2 No No Natural 3 Natural 2 No No Natural 3 Natural 4 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined Sep 2, 2007 to 1 Natural 2 No No Natural 2 No No Natural 3 Natural 2 No No Natural 3 Natural 4 Natural 4 Natural 5 Pending Investigation 3 Natural 2 No No Natural 3 Natural 4 No Natural 4 No Natural 5 Pending Investigation 3 Natural 4 No Natural 5 Pending Investigation 3 Natural 5 Pending Investigation 3 Natural 5 Pending Investigation 4 No /ital sician: is certil	Be	examiner?	lospital: 1 Inpatient 2	ER/Outpatien)ther:		Residence 6 🗸 0	her: Scene	
			27. Manner of Death	28a. Date of Injury	28b. Time of	Injury 28c. Injury	/ at Work?	28d. Describe h	ow injury occurred	
	isio	ficati	2 Accident Investigation	28e Place of Injury	At home, farm, stre		ilding, etc.			
	Div pital or ours aft filled in	Serti	determined		treet		į.	or Town, St NB Willowbrod	ate) ok Road, Frederic	c, MD
	Hos 24 h Fun stely		(Check only Certifying Physici							
and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	To the within To the Comple	Medical	1							
O.C.M.E. September 2, 2007			(Lalute	us)		O.C.N	1,E.		September 2,	2007
30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	5		·	,		Street Politim	ore MD 2120	01		
Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Ref Strar's Signature		tate					IOIE, IVID 2120) I		

			For State of Maryland / State Registrar	Certificate of	leaith and Me Death	ental Hygle Reg.	ne 2007	30208					
	Physici	an	Decedent's Name (First, Middle, Last) Lawrence Albert Hemp			2. Date of Death	□¥2, 2007	3. Time of Death 12 Noon M					
TO SEE	/Medic Examin		4a. Facility Name (If not institution, give street and number) 5325 Wye Creek Drive		Location of Death		4c. County of Death	±k					
Ì	Funeral Director		5. Social Security Number 220-26-7402 6. Sex 12 M 2□F 7. Age (In yrs. last In the security Number 12 M 2□F 76			8. Date of Birth (Month, Day, Ye Jan 28,	9. Birthp 1931 Mary	olace (State or Foreign Tand					
	Maryland a-f show ified at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, To Maryland Frederick 10c. City, To	wn or Location Frederick			1	0d. Inside City Limits 1 □Yes 2 🕱 No					
	3a or 28	al Dire	10e. Street and Number 5325 Wye Creek Drive	10f. Zip Code	21703	10g.	Citizen of What Cour	ntry?					
036	ours after death ral", or Items 2 Examiner mus	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Maryes 2 □ No 1952-1874 (Fyes, Give Year or Dates: 1954)	13. Was Decedent of H if Yes, specify Cuba 1 ☐ Yes 2 No		cify Yes or No- lican, etc.)	14. Race - Americ Black, White, Specify: W						
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4	Sa. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired General Mana	nd of work done during most of working NOT use retired)			dustry					
and 2		Be	17. Father's Name (<i>First, Middle, Last</i>) Lloyd Hemp		18. Mother's Name Virgini		,	Allen					
Maryl	d 2 should the and Me 7 is mark	2	1 (),	9b. Mailing Address (Street : 5325 Wye Cree	and Number or Rural	Route Number, C		,					
Baltimore, I	Pages 1 and nent of Health ant: If item 27 ury or other t		20a. Method of Disposition 20b. Place ceme 1 X Burial 2 Cremation 3 Deemoval from State	of Disposition (Name of tery, crematory or other place ivet Cemetery	ce) Da	ate 200	c. Location - City or To rederick,	own, State					
Balti	permit. Departr Importa any Inju		21. Signature of Funeral Service Uterisee	22. Name and Addres Keeney and 106 East	s of Facility d Basford Church St.	PA Funer Freder	al Home	21701					
-	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. a. a. a. a. a. a. a. a. a. a. a. a. a										
Get .	/Medical Examiner		Due to (or as a consequence		•								
S	ecuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause).										
68760, %	ate be exe aysician a he burial-	edical Ex	Due to (or as a consequence d.	е от):									
.O. Box 68	death cel e attendir d for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dec 4 ☐ Pregnant at time of death		у		23d. Date of deliver	ery Day Year					
<u>α</u>	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting	ı in the underlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to t	he cause of death? bably 4 ∐Unknown					
or Vital Records,	2 38	Completed				24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of					
·Vita	Physician: this certific	To Be (25. Was case referred to medical examiner? 1 Yes No Hospital: 1 Inpatient 2 ER/	Outpatient 3 DOA Oth	26. Place of Death ner: 4 ☐ Nursing Hom		ce 6 □Other (Specia	fv)					
on or	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page			o. Time of linjury 28c. Injury Wor		8d. Describe how		<i>y</i>					
Division	after dea after dea Director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, street, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,					
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled and manner stated.	lge, death occurred at the til and/or investigation, in my o	me, date and place, a opinion, death occurre	and due to the caused at the time, date	se(s) and manner as s e and place, and due t	itated. o the cause(s)					
	To the within To the comp	Me	29b. Signature and title of certifier	29c. Licens	se number	29d	Date signed (Month,	Day, Year)					
	10		30. Name and address of person who completed cause of death (Item 238 ET hamy ES Fander, M) 3	a) (Type, Print) 7th	street	Frederic	K.MD	21701					
	Sta Regist		31. Date filed (MStr. Pay, Year) 2007 Registrar's Signifure		<u> </u>	, , = - (, - (

DHMH 17 Rev 1/2001

			1 - State Registrar		epartment of Health ai Ce <i>rtificate of Death</i>		gie z e UU / leg. No.	30207	
	Physic	an	Decedent's Name (First, Middle, Last)			2. Date of Dea Month			
	/Medi	cal	Evelyn Irene	Howard		Septemb	er 15 200	07 5:50P ^M	
	Examii	ier	4a. Facility Name (If not institution, give street and Dove Hospice House	number)	4b. City, Town, or Location of Westminst		4c. County of Death Carroll		
13.	Funeral		Social Security Number	7. Age (In yrs. last birth	day) If Under 1 Year If Under 24	Hrs. 8. Date of Birth) 9 B	irthplace (State or Foreign	
	Director		219-20-3153	^F 90 Y	s. Months Days Hours	Min. Aug. 22	Year) /	Country) ary land	
	land bw t		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town of	or Location			10d. Inside City Limits	
	Mary i-f sho fied a	ţō	Maryland Carroll		Union Bridge			1 ☐ Yes 2 X No	
	or 28a e noti	Director	10e. Street and Number	L	10f. Zip Code	1	0g. Citizen of What 0	 Country?	
	ath wi	rai	1250 Marble Quarry Ro		21791			.S.A.	
	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	Arme	Decedent Ever in U.S. I Forces? es 2 No	 Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I 	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.	
21215-0036	ours at al", or Exam	þ	If Yes	Give or Dates:	1 ☐ Yes ※ ☐ No <i>Specify:</i>		Specify:	Black	
2-0	72 hc "natu dical	eted	15. Decedent's Education (Specify only highest grade complet	ed) ((ecedent's Usual Occupation Give kind of work done during most o	f working	16b. Kind of Busines		
121	within ene. than '	Completed	Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	ife. DO NOT use retired) clerk	. Working			
d 2	illed Hygi other ent, ti	Be Co	17. Father's Name (First, Middle, Last)			Name (First, Middle, I	book sh	ор	
Maryland	Menta	To B	Charles Roberts			y Brooks	,		
Jan	2 should and Mer is marke raumatic		19a. Informant's Name/Relationship (Type. Print)		Mailing Address (Street and Number		, City or Town, State,	Zip Code)	
	1 and Health em 27 other tr		George J. Howard/ husb 20a. Method of Disposition		O Marble Quarry I		Bridge,		
πor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 □ Cremation 3 □ Removal fr □ Donation 5 □ Other (Specify)	on State	isposition (Name of crematory or other place)		20c. Location - City o		
altimore,	permit. F Departm Importar any injur		21. Signature of Funeral Service (Specify)	60	Cemetery 9/ 22. Name and Address of Facility	19/2007 Hartaler F	Uniontown,	,_MD	
<u> </u>	a III o		atharine V. Xa	eller	6 E. Broadway	Union Br	idge, MD 2	16 21791	
4 3			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do not in each line.	enter the mode of dying, such as ca	rdiac or respiratory arre	est,	Approximate Interval Between	
is the	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	COF	D			Onset and Death	
	Examiner			to (or as a consequence of):	- FIBROSIS			214EAR	
٨	70 #	ner	Sequentially list conditions, it is a sequentially list conditions, it is a sequentially list cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):	1 11512015			- 1 PLITA	
22,	ecuter and transi	Examiner	c.						
68760,	burial		Due	to (or as a consequence of):					
89	tificate be executed g physician and as the burial-transit	edical	d						
		hysician/l/	LOD: Was decedent pregnant	outcome pf pregnancy re birth 2 Fetal death	3 □Ectopic pregnancy		23d. Date of de	elivery	
o.	requires that the death cer een signed by the attendir nould be detached for use	ysici		egnant at time of death known	5 Other (specify)		Month	Day Year	
ت. ت	w requires that the d been signed by the should be detached	0	Part II. Other significant conditions contributing to	death but not resulting in th	e underlying cause given in Part I.	23e. Did tob	acco use contribute t	to the cause of death?	
Records,	equires en sign	ed by				1 □ Ye	s 2,21No 3□F	Probably 4 ∐Unknown	
		Completed				24a. Was ar		utopsy findings available	
_		S				— autops perform 1∐ Yes 2	prior to ned? death?	completion of cause of s 2 □ No	
VITAI	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1		O4h	Death (Check only one		DOVE HOSPICE	
ō	g Phy er this eral d	2	27. Manner of Death 28a. Da	te of Injury 28b. Tim	e of 28c. Injury at	ng Home 5 Reside		ecify) HOUSE	
SION	Attending r death. ector: After by the funer	atio	2 Accident investigation	onth, Day Year) Inju	ry Work? M 1 ☐ Yes 2 ☐ No		,,		
Ĕ	or Att fler de Direct in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Pla	ice of injury - At home, farm, ilding, etc. <i>(Specify)</i>	street, factory, office	28f. Location (Str City or Town	eet and Number or R , State)	Bural Route Number,	
_	spital ours a neral I		29a. Certifier 1 Certifying Physician: To	the hest of my knowledge, do	eath occurred at the time, date and p	Jaco and due to the co	(-)		
:	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	Medical	ZE INCUICAL EXAMINET. OF THE	basis of examination and/o	r investigation, in my opinion, death	occurred at the time, da	ate and place, and du	e to the cause(s)	
	Vithi To th	ž	29b. Signature and title of certifier	1	29c. License number		d. Date signed (Mon	th, Day, Year)	
			Man ()	TO	D005955	2	9/17/0	7	
	5		30. Name and address of person who completed ca		pe, Print) TODA POOLE RD	INF ST as	-0 -07 7	1150	
	Stat	е		Registrar's Signature	NO S	VILSI MIN ST.	EXC MID of	//3 //	
	Registra	-	SEP 2 0 2007	Registrar's Signature	EAST.				

C	Type of I this in P	aon maonaid min		
	State of Mandand	/ Department of H	ealth and Mental	Hygiene
	State of Marviano	/ Department of Fi	ealli and Mena	LIVUICIIC

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		- For State Registrar		Certific	cate of i	Death	_	_		eg. No.	L. 0		
Physicia		1. Decedent's Name (First, Midd	le,Last)						Date of Dea Month	Day	Year	3. Time of Death	
adical Examin	ıer	Flinard An	dre' Ho	ough					August 30	0, 2007		2052 hrs	
	•	4a. Facility Name (if not institution Prince Georges Hosp									nty of De e Geor	ge's	
Funeral	1	5. Social Security Number	6. Sex	7. Age (In yrs. last b	irthday)	If Under 1 Y	ear If	Under 24Hrs	8. Date of Bi	rth (MM/DD/Y	YYY) 9.	Birthplace (State or Foreign	
Director	- 1	578-82-9353	1XM 2 F	41	Yrs.	Months E	Days H	lours Mir	Sept.	22, 1	965	Country) Washington, I	
à.		Usual Residence of Decedent 10a, State 10b, County	· · · · · · · · · · · · · · · · · · ·	10c. City, Tow	n or Locatio	n						10d. Inside City Limits	
nd show any ice.	-	,	NTGOMERY		ville						1	1 XYes 2 No	
ih the Maryland 23a or 28a-f show totified at once.	Director	10e. Street and Number				10f. Zip Cod	е		1.57	10g. Citizen o	f What C	ountry?	
the Na or S		14128 Arbor_F	orest Dri	ve		208	50					tates	
, MD 21215-0036 and 2 should be filed withn 72 hours after death with the Maryland eath and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f she transmatic event, the Medical Examiner must be notified at once	uneral	11. Marital Status 1 X Never Married 2 N	12. Was De	cedent Ever in U.S.		Decedent of s, specify Cu			pecify Yes or N Rican, etc.)		White, etc	nerican Indian, Black, African	
fter d	by F	3 Widowed 4 D	vorced If Yes, Give Ye		1	Yes 2 X	No sp	ecify:		Spec	cny.	merican .	
ours a latura xamir		15. Decedent's Education (Sp				s Usual Occu st of working					of Busine	ss/Industry	
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Ore, MD 21215-0036 ss 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 is marked other than ther transmatic event, the Medica	BeC		s, Last)	•				Elise					
212 uld be Ment mark	믱	Fred Hough 19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailing	Address (S	Street and	d Number or	Rural Route No	ımber, City or	Town, S	tate, Zip Code)	
nore, MD 2 ages 1 and 2 shou nt of Health and N t: If item 27 is n other traumatic		Brenda Graves	- Sister	Y	3202	East C	Capit	tol St	., NE W	ashing	ton,	DC 20019	
e, e, land land Healt litem	ı	20a. Method of Disposition 1 XBurial 2 Crematic			e of Disposinatory or oth	tion (Name of er place)	f cemete	ery,	Date	20c. Loca	ition - City	or Town, State	
Baltimore, sermit Pages I an Department of Hec Important: If ite		1 ABurial 2 Cremation 5 Other			cwell	Cemete	ery	Sep	t. 10,	2007 Y	ance	yville, NC	
Baltimo permit Page Department o Important: injury or oth	٠-	N. Signature of Funeral Service	e Licensee	AAA	22. N	ame and Add	iress of F	Facility St	ewart I	uneral	Hon	ie, Inc.	
00 99 2 E		!Which!	Mly	ON THE	40	01 Ber	ning	g Road	, NE Wa	shingt	on,	DC 20019 Approximate Interval	
Physician		23a. Part I. Enter the disease, failure. List only one caus	or complications that se on each line.	caused the death. Do	not enter th	e mode of dy	ng, suci	n as cardiac	or respiratory a	rrest, snock,	ornean	Between Onset and Death	
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		or condition resulting in death)	Due to (or as	a consequence of).	- 4								
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	Examiner	(Disease or injury that initiated	C	a consequence of):			_						
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687 ertific ding p	au/	23b. Was decedent pregnant in past 12 months?	Pro	birth gnant at time of death		tal death		Ectopic preg	nancy	Mo	nth	Day Year	
Box 68 s death certifulth attending ed for use as	/sic	1 Yes 2 No 9 L	-t	nown	5 Oth	ner (Specify)	-						
P.O. Box 687 s that the death certific gned by the attending p	F	Part II. Other significant cond	ditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?			
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tal Rection The certificate ector, page		25. Was case referred to medi	cal			26.	Place of	Death (Ched					
Vita ysician his cer	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 🗸 EF	R/Outpatient	3 DOA	Oth	ner ₄ Nur	sing Home 5	Residence	6 0	Other:	
Division of Vital Records, P.O. hal or Attending Physician: The law requires that the sa dred cleath. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached.	n: To	27. Manner of Death	28a. Da	nth Day Year)	3b. Time of I	, , I		at Work?		e how injury		fixed object and	
ion tendir eath. for: A	tio		vestination		804 hrs			2 🗸 No	ejected				
ViSi or Att fter de Direct in by	ific	3 Suicide 6 C	ould not be 28e. Pl	ace of Injury - At home	e, farm, stree	et, factory, of	fice build	ding, etc.	or Towr	. State)		or Rural Route Number, City	
Divis Hospital or A 24 hours after Funeral Dire	Certification:	4 Homicide		か Parking Lot					1	el Bowie Ro			
Division of Vital Records, P.O. Box 68760, To the Itospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitive to the purial of the control of the purial of the		29a. Certifier (Check only one) Certifying	Physician: To the bas	est of my knowledge, is of examination and	death occur	rred at the tin	ne, date . pinion. de	and place, a eath occurre	nd due to the ca d at the time, da	ause(s) and nate and place,	nanner as , and due	stated. to the cause(s)	
To the Ho within 24 h To the Fur completely	Medical		and manne	r stated.	- mresuga		icense n					(Month, Day, Year)	
	Σ	29b. Signature and title of cert	^ \				D.C.M.				st 31, 2		
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12(2)		30. Name and address of pers	on who completed ca tant Medical Ex			et, Baltimo	ore, Mi	D 21201					
	4(<u> </u>				
5	tate trar		Fra.	Registrar's Signature	Me								

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 3021 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 25 Day 2007 Year **Physician** Hamilton 6:00P Rose /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Heartland Nursing Home Hyattsville 8. Date of Birth 1929 9. Birthplace (State or Foreign (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗷 F Months 577-34-9186 North Carolina Director October 26 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show "natural", or items 23a or 28a-f shovedical Examiner must be notified at Washington, DC 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 20011 USA 5935 3rd St. NW Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d other than " Elementary/Secondary (0-12) College (1-4or 5+) Sterile Technician Private 12th17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Walton Is marked Lloyd Lee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 Is any Injury or other traun 5935 3rd St. NW, Washington, DC Milton Hamilton/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National Cem. 8/31/07 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatule of Funeral Service License 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St. NW, Washington, DC 23a Part1. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed SEPTICEMIA physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes ed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an has autopsy page certificate 1□ Yes 2 M No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Hospital or Attending Injury 1 X Natural 5 Pending 2 🗌 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) UNYELIAR 7325 A SEP 0 6 2007 32. Registrar's Signature 31. Date fi Registrar

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			Registrar					Cel	uncai	te or i	Jeath			Reg. N	0.		
			1. Decedent's Name (First, Mid	die, Last)								2. Date of D				3. Time of Death
	Physici		Melvin Hollis	Hard	estv								Septe	mber	^{ау} 3 :	2007	03:15 P M
1	/Medi Examir		F The No. of the control of the cont						4b. City	. Town, or	Location o	f Death	Dopus		4c. County of Death		
	CXAIIIII	iei	Anne Arundel Medical Center							napo.					Anne		nde1
			5. Social Security Number				(In yrs. las	t hirthday)		r 1 Year	If Under 2	24 Hrs	9 Date of B				
	Funeral			1[XM 2□F	7. Ago (Yrs.	Months		Hours	Min.	8. Date of B (Month, D 11/29	ay Year	7	Cou	place (State or Foreign
	Director	Į	214-50-9450 Usual Residence of Decedent				_70	110.		l			11/29	/193	0	Mary	land
	pug ≱		10a. State 10b. Coun	tv		1	10c, City,	Town or Lo	cation							1.	I0d. Inside City Limits
	anyll.	5					•										1 ☐ Yes 2 X No
	88 - 88 - 1	Sct	Maryland Anne	Aru	ndel		Edgew	ater									
	or 2	100	10e. Street and Number							p Code					itizen of V		
	23a	<u>a</u>	331 Londontowne Road						2	1037				Uni	ted S	State	es
	des	ne	11. Marital Status		12. Was Dec Armed F		er in U.S.	13. \	Vas Dece	dent of Hi	spanic Orig	gin? (Spe	cify Yes or N Rican, etc.)	10-	14. Race - American Indian, Black, White, etc.		
ထွ	or it	F	1 Never Married 2 Married 1 Yes			2 XNo						, 1 4010 1	110411, 010.7				etc.
င္တ	ours	5	3 ☐ Widowed 4 ☐ Divorce	ed	Year or I			1 ☐ Yes 2 🛣 No Specify:						Specify	" Whi	te	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Iteme 23a or 28a-f show inthe the Medical Exactif writinal for putified at	Completed by Funeral Director	15. Deced (Specify only high	ent's Edu	cation)	1	16a. Deced	ent's Usu	al Occupa	ation during most	of working		16b. l	Kind of Bu	usiness/In	dustry
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2	in the state of th	0	8			(, ,,,,		Farme	er					Ag	ricu:	lture	9
ਰ	ent, ent	Be	17. Father's Name (First, Middl	, Last)							18. Mother	r's Name	(First, Middl	le, Maide	n Suman	ne)	
<u>a</u>	d be with the contract of the	To B	Hollis Ward H	arde	sty						Bess	ie Pe	errie				
2	mar mat	-	19a. Informant's Name/Relatio					19b Mailin	n Addres	s (Street a	and Number	r or Rurai	Route Num	her City	or Town	State Zir	Code)
Maryland	d 2 s th ar 7 le trau																
ص ص	permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Departmant of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Iteme 23a or 28a-f show any injury or other traumatic event, the Madical Examinating the notified at once.		G. Lorraine Re	ттте	r/Sist	er	20h Plac	e of Dispo			bad, s		sbury,				SUI own, State
ō	1 or o		1 Burial 2 ☐ Cremation	1 3 □F	Removal from	State	cem	netery, cren	natory or	other place	e)						
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Baltimore,	permit. Depart Import any inj		21. Signatura al Septic	e Licens	99			22	. Name a	nd Addres	s of Facility	Geo	rge P.	Ka1	as F	uner	al Home
—	40 E # 9		· wala					29	73 Sc	10mo	ns Is	1and	Rd.,E	Edgew	ater	, MD	21037
			23a. Part1. Enter the disease, shock, or heart failure. Li	or compl	lications that	caused th	ne death.	Do not ente	er the mo	de of dying	g, such as o	cardiac or	respiratory	arrest,			Approximate Interval Between
	Pnysician		Immediate Cause (Final	or only o													Onset and Death
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87	n certificate be executed anding physicien and use as the burial-transit	n/Medical														-	
ox 68760,	ing p	Me	IF FEMALE:														-
	th ce tend	an/	23b. Was decedent pregnant	2	3c. If yes, ou 1□Live		pregnancy ☐ Fetal de	y eath 3□	Ectopic p	regnancy						e of delive	•
	a dea	S	in the past 12 months? 1 ☐ Yes 2 ☐ No		4∐Preg 9∐Unkr		ne of deat	h 5 🗆	Other (s	pecify)					Moi	nın	Day Year
Division of Vital Records, P.O. B	Attending Physician: The law requires thet the death is deeth. ector: After this certificate has been signed by the attention that the funeral director, page 2 should be detached for upy the funeral director, page 2.	by Physicia	9 Unknown		3LJ 011KI								_				
'n	s the	Ž	Part II. Other significant condi					ng in the ur	derlying	cause give	n in Part I.		23e. Did	tobacco	use conti	ribute to t	ne cause of death?
ë	quire n siç uld b	D D	RENI	1	FAIL	المحر ا	5						1 🗆	Yes 2	No	3 Prob	ably 4 Unknown
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æ	has ge 2	Completed	24a. was an autopsy performed?								5	prior to co	psy findings available impletion of cause of				
a	icate	ပိ		_									1 Yes	26 N	o 1	I ☐ Yes	2□ No
⋚	ician certii	Be	25. Was case referred to medic examiner?		fospital: 🔏	,				Othe	AC.		(Check only				
5	Phys this al dir	ဥ	1 ☐ Yes 2 No		110	Inpatient		VOutpatien		JA	4 Nur		e 5 Res				y)
_	ing f	o	27. Manner of Death 1 Manual 5 ☐ Pend	ing	28a. Date (Mor	of Injury oth, Day Y	/ear) 28	Bb. Time of Injury		28c. Injury Work			8d. Describe	how inju	iry occurr	ed	
<u>S</u>	eeth or: /	cat	2 Accident inves	tigation					М	1 🗆 \	/es 2 □ N	10					
Ξ	r Ati	ŧ	4 Homicide deter	mined	28e. Place build	e of Injury ling, etc. (· - At home (Specify)	e, farm, stre	et, factor	y, office		2		(Street a		er or Rura	I Route Number,
	rs af	Certification:			1								_				
	To the Hospital or Attending Physician: The lav within 24 hours after deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certify (Check only 2 Medic	ing Phy	sician: To the	e best of	my knowle	dge, death	occurred	at the tim	e, date and	place, a	nd due to the	e cause(s	s) and ma	inner as s	tated.
	n 24 n 24 he Fi	edical	one)		and mar	ner state	xamination d.	and/or inv	estigation	ı, ınımyop	enion, death	n occurre	u at the time	, date an	ia piace, a	and due to	the cause(s)
	To the Tour	ž	29b. Signature and title of certif	ier					29	c. License	number			29d. Da	ate signed	d (Month,	Day, Year)
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			30. Name and address of person	n who er	ompleted cau	se of dear	th (Item 21	3a) (Tyne I	1	-		t				. 0	
	HOW	7	Douglas mit	che	1 20	101 n	Nedi	10	1	WAY	An	O(1)	ilis, L	Ad	210	(0.1	
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	Registr		SEPI		107	Co.	_ 1 _ 4	K A	Card								

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	Cei	rtificate of	Death		2007	30213
	Physici /Medi		1. Decedent's Name (First, Middle, Last) William Hall				2. Date of Death Month	Day Year	3. Time of Death 11:50 A M
}	Examir		4a. Facility Name (If not institution, give street and number)	7	4b. City, Town, o	or Location of Death		4c. County of Death	nal
2	Funeral Director		130-14-0336 X M 2□F 8	rs. last birthday) 32 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, \) 02/18/19	Year) 9. Birthy Court New	place (State or Foreign htry) York
	yland how at		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	eation			1	10d. Inside City Limits
	the Mar 28a-f sl	ector	Maryland Anne Arundel E	dgewate			10	Citizen of Mallert Court	1 ☐ Yes 2 ☐ No
	th with 23a or 1st be n	al Dir	3625 Branhum Road		10f. Zip Code 21037		1 '	g. Citizen of What Cour Inited State	•
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depardrment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 1 □ Never Married 2 ☐ Married 1 □ Never Married 2 ☐ Married 1 □ Mes 2 □ No			lispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	
2-003p	hours a tural", o al Exan	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 194		1 ☐ Yes 2 M☐ No dent's Usual Occup	Specify:		Specify: Whi	
<u>-</u>	ithin 72 ne. Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	kind of work done DO NOT use retired	during most of working d)	7	6b. Kind of Business/In	·
70	filed within Hygiene. other than ' ent, the Me	a)	12 17. Father's Name (<i>First, Middle, Last</i>)	Cable	Splicer	18. Mother's Name		elephone Co	ompany
yland	should be and Mental s marked o umatic eve	To B	George Hall	1		Elsie Her			
Ma	and 2 sh ealth and n 27 Is m		19a. Informant's Name/Relationship (Type. Print) Constance B. Hall/Wife					City or Town, State, Zip Maryland 2	
ore,	Pages 1 a nent of Hez int: If item iry or othe		20a. Method of Disposition 20b 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State	p. Place of Dispo cemetery, cren	sition (Name of matory or other plac			Oc. Location - City or To	
Dallimor	permit. Pa Departmen Important: any Injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Berviga Heense	Kalas Cr	ematory Name and Addre	09/06	/2007 E	Edgewater. alas Funera	Maryland
Ŏ	permit Depar Impor any In		Med. En	2 29	9/3 Solom	ons Island	Rd., Edg	gewater, MD	21037
	Physician		23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	594555	er the mode of dyir	ng, such as cardiac or	respiratory arres	it,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) a. Due to (or as a cons		<i>C</i> /				10 months
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or Injury	equence of):					
	executer and al-transi	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last C. Due to (or as a cons	equence of):					
00/00	rtificate be executed ng physician and s as the burial-transit	Medical	d		· .				
	n certific ending p use as	n/Mec	IF FEMALE: 23c. If yes, outcome pf preg					23d. Date of delive	erv
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L 'CD'	uires that signed to d be deta	þ	Part II. Other significant conditions contributing to death but not re	esulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to th	ne cause of death?
מנס	law req as been 2 shoul	Completed					24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
ב	n: The flicate h or, page		25. Was case referred to medical				performe 1□ Yes 2	ed? death?	2 No
, ,	hyslcia his cert il direct	To Be	examiner? 1 Yes No Hospital: 1 Inpatient 2	☐ ER/Outpatient		26. Place of Death (er: 4 ☐ Nursing Home		ce_6 □Other (Specif	y)
5	nding P th. : After t e funera		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	yat k? Yes 2 ∐No	d. Describe how	injury occurred	
CIVIS	al or Atter after dea I Director d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At building, etc. (Spe	home, farm, stre cify)	eet, factory, office	28	f. Location (Street City or Town, S	et and Number or Rura State)	l Route Number,
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of exami and manner stated.	nowledge, death ination and/or inv	n occurred at the tirvestigation, in my o	me, date and place, ar pinion, death occurred	nd due to the cau d at the time, date	ise(s) and manner as si e and place, and due to	tated. the cause(s)
	So Twithin	Me	29b. Signature and title of certifier		29c. License	e number) (A379	29d	1. Date signed (Month,	Day, Year)
1	9. B		30. Name and addr ss of person who completed cause of death (It		Print)	Side RUD	Annal	200	(A)
Ŋ	Sta		31. Date filed (Month, Day, Year) 32. Begistrar's Sig	130.5		30.00	11/1/0/	े गण यर	01
	Registr		SEP 0 5 2007	1 As	ode				

Physician /Medical **Examiner**

if item 27 or other t

Department of H important: if ite any Injury or ot once.

Physician

/Medical

Examiner

Funeral

Director

r 28a-f shov notified at

"natural", or items 23a or edical Examiner must be

Maryland

Baltimore,

Pages

JOSeph

Director

Funeral

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Completed

Be

Examine

burial-tran attending properties for use as signe be page 2 s director,

law requires that the death certificate be executed by Physician/Medical Certification: To

Hospital or Attending 24 hours after death Funeral Director: filled in by mpletely within 24

Division or Vital Records, P.O. Box 68760,

Completed by Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year		
	Part II. Other significant conditions of the Cholester (contributing to death but not resulting in the und	derlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
				24a. Was an autopsy performed? 1 ✓ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No		
Be (25. Was case referred to medical examiner?		26. Place of Dea	ath (Check only one)		
To E	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing H	Home 5 Residence 6 □Other (Specify)		
Certification: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred		
	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)				
Me	29b. Signature and title of certifier	^	29c. License number	29d. Date signed (Month, Day, Year)		

121613

Beach Rd PASADENA, MD 21122

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

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Magothy

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death State of Maryland / Department of Health and Mental Hygiene Certificate of Death	5										
	Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 1. Decedent's Name (First, Middle, Last)	eath p										
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	7										
		8	5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Rightholace (State or F.)											
k.	Funeral Director		216-54-9239 19M 2 F 56 Yrs. Months Days Hours Min. (Month, Day, Year) Country Maryland	oreign										
	aryland show d at	lan.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City L	40										
	th the Market sor 28a-f	Funeral Director	VA Accomack Parksley 10e. Street and Number 10g. Citizen of What Country?	No No										
	leath wil	eral D	26463 Metompkin Kd., Aptaly 23421 United State. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian,	<u></u>										
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 ☑ No Specify: Specif											
1215-(within 72 h ene. than "natu he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) FURNITURE TN dUSTRY	,										
and 2	e filed with al Hygiene. I other thar vent, the N	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)											
ryla	should be nd Mental marked o	2	Thomas Hudson ElAINE DENNIS											
, Mary	1 and 2 sho Health and em 27 is ma		19a. Informant's Name/Relationship (Type. Print) Shelley A. Hudson (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1745 Woodbridge, VA 2219	5										
Baltimore	Pages 1 nent of H nt: If iter ny or oth		20a. Method of Disposition Date 20c. Location - City or Town, State											
3altii	permit. Pag De artment Imp. rtant: II fm. injury o	-	BEING AUGUST OF THE STREET											
	00 340		23a. Part1. Emer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Betwee	<u>/</u>										
No.	Physician /Medical Examiner		shock, or heart failure List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Initerval Betwee Onset and Deat disease or condition	n th										
		Son	Due to (or as a consequence or):	0										
0	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
ó	icate be executed physician and sthe burial-transit		that initiated events ' c											
928	icate be physici s the bu	dical	d											
.O. Box 6	ath certif attending for use a	ysician/Me	ysician/Me	ysician/Me	ysician/Me	ysician/Me	ysician/Me	ysician/Me	ysician/Me	ysician/Me	ysician/Me	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23d. Date of delivery Month Day Year	r
Д.	ires that the de signed by the a be detached i	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death											
ord	w require		Jeveri Caroliomo patry 1 Yes 2 No 3 Probably 4 Dunkr											
or Vital Records,		Completed	24a. Was an autopsy findings avai prior to completion of cause death? Yes 2 No 1 Yes 2 No	lable e of										
Vita	Physician; Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No											
l Or	g Phy: ter this teral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred											
Division	or Attending after death. Director: After in by the funer	catio	2 Accident investigation M 1 Yes 2 No											
Divi	tal or At s after d al Direc ed in by	Certification:	28e. Place of injury - At home, farm, street, factory, office determined determined building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)											
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	vithir To th comp	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)											
	Dru		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
	Sta	te	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Basuel 100 E. Carroll St. Salisbury MD 21801 31. Date filed (Month, Day, Year) 32. Registrar's Signature											
	Registr		31. Date filed (Month, Day, Year) SEP 0 4 2007 32. Projector's Signature											

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 1821 Hall Patti September 01 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital Hopkins Johns Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Min. 1 ☐ M 2 🔀 F Days Hours 50 **Director** 220-66-4353 12/23/1956 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10h County 10d. Inside City Limits 28a-f sh 1 ☐ Yes 2 X No Director Maryland Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r 7765 Holt Road 21849 USA Funeral 'natural", or items dical Examiner ma 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt; If Item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 👿
If Yes, Give
Year or Dates: 2 🔀 No 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XQo Specify: þ Specify: white 3 Widowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Physical Clerk Holly Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Ralph Riley Virginia Lee Brown ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank H. Hall/husband 7765 Holt Rd., Parsonsburg, MD 21849 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ■ Burial 2 □ Cremation 3 □ Removal from State 9/5/07 Jerusalem Cemetery 4 Donation 5 Dother (Specify) Parsonsburg, MD ure of Funeral Service Licensee ^{22. Name and Address of Facility}
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CFSP Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ventricular Fibrillation disease or condition resulting in death) minutes /Medical Due to (or as a consequence of): Examiner ou tension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed Septic Shock 2 hours attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Division or Vital Records, P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ardiomyopathy 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No ate has b 24a. Was an performe 2 No 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check onl one 1 Yes 2 No Hospital: Other: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? 28b. Time of After 1 28d. Describe how injury occurred al or Attending F 1 Natural 2 Accident (Month, Day Year) 5 Pending Injury To the Hospital or Attendi within 24 hours after death.
To the Funeral Director; A completely filled in by the fu investigation 1 □ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D. Medical Doctor Res-000 September, 01, 2007 10mx 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hares Najand, Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287 31. Date filed (Month, Pay, Year) 32. Reastrar's Signature State 0 4 Registrar Margare,

		For State Registrar		State of Ma	aryiano	Depa <i>Cei</i>	artment of F rtificate of I	lealth a Death	and Me	ntal Hyg	giene Reg. No.	2007	30217
Physici	an	1. Decedent's Nam	ne (First, Middle, La	st)					2	2. Date of De Month	ath Day	2, 2007	3. Time of Death
/Medi	cal		eslie Iser	1 e street and number)			4b. City, Town, or	r I coation o		eptemb		County of Deatl	9:58 A M
Examir	ier	Casey Ho		e street and number)			Rockvill		oi Dealli			ntgomer	
Funeral		5. Social Security I	Number 6. S		e (In yrs. la	ast birthday)	If Under 1 Year Months Days		24 Hrs. 8 Min.	B. Date of Birt (Month, Da	h		nplace (State or Foreign untry)
Director		138-46-9	96/5	□ M 2K□ F	57	Yrs.	Months Days	riouis	S	ept 21	, 19	949 New	Jersey
fand Dw		Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo	cation				-		10d. Inside City Limits
Mary a-f sh	tor	MD	Montgome	erv	Silv	er Spi	ring						1 ∐ Yes 2 🛣 No
th the or 28¢ e noti	Director	10e. Street and Nu					10f. Zip Code				10g. Citi	zen of What Co	untry?
ath wi		9118 Bra	adford Roa				20901				USA		
ter des Items ner m	Funeral	11. Marital Status	rried 2 🕅 Married	12. Was Decedent 8 Armed Forces?		5. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Ori an, Mexicar	igin? (Speci n, Pu <i>e</i> rto Ri	fy Yes or No can, etc.)	•	 Race - Amer Black, White 	
If it is not a start of the many and filed within 72 hours after death with the Maryland Hyglene. Other than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	3 ☐ Widowed		1 ☐ Yes 2 ☒N If Yes, Give Year or Dates:			1 ☐ Yes 2 💢 No	Specify:				Specify: Whi	.te
72 hor	eted	(Spe	15. Decedent's Ed	ducation ade completed)		16a. Dece	dent's Usual Occup	ation during mos	at of working		16b. Ki	nd of Business/I	
ithin ne.	Completed	Elementary/Sec		College (1-4or 5		life. I	DO NOT use retired	i)	. o. noming		- 1		
filed w Hygie ther t		17. Father's Name	(First, Middle, Last	<u> </u>	1	Teache	er	18. Mothe	er's Name (First, Middle,		Surname)	
ld be fental l	To Be	Jack Huf		,					hy Ly		Wide a	ournamo _j	
shoul and M	ř.		Name/Relationship (Type. Print)		19b. Mailir	ng Address (Street	and Numbe	er or Rural i	Route Numbe	er, City o	r Town, State, Z	ip Code) 22003
and 2 salth a n 27 is		Robert I	Isen/husba	and			Little R		Turnp	ike #1	.200	Annanda	le, VA
Figure 1		20a. Method of Dis 1 ☐ Burial 2	MCremation 3 □	Removal from State	- 1		sition (Name of matory or other plac		Dat			cation - City or	
tt. Pa rtmen rtant: njury		4 ☐ Donation	5 ☐ Other (Special	ý)	Che		ke Cremat		09/05			sville,	
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, the Medical Once.		21. Signature/of F	Funeral Service Lice	E Little	МО		2. Name and Addre Ding Home everly L.	Crem Heck	ation rotte	Servi	.ce Cla	P.O. Boarksvill	x 784 .e, MD 21029
		23a. Part1. Enter shock, or he	the disease, or com art failure. List only	plications that caused one cause on each lin	the death	. Do not ent	er the mode of dyir	ng, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
Physician		Immediate Cause disease or condition resulting in death)	on	a. Pancreat	tic C	ancer							Onset and Death
/Medical Examiner		resulting in death)		Due to (or as	a consequ	ence of):							
	er	Sequentially list co	onditions, mmediate	b. Due to (or as	a consequ	ence of):							
cuted nd ransit	Examiner	Sequentially list or if any, leading to in cause. Enter Und Cause (Disease of that initiated event)	injury ts	C									
be executed sician and burial-transit		resulting in death)	Last	Due to (or as	a consequ	ence of):							
the cate	edical			d									
	n/Me	IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, outcome	pf <u>pr</u> egnar	ncy						23d. Date of deli	verv
The law requires that the death cert the has been signed by the attending age 2 should be detached for use its	hysician/M	in the past 12	2 months?	1□Live birth 4□Pregnant at			∃Ectopic pregnancy ∃Other <i>(specify)</i>	/				Month	Day Year
at the de	Phys	9 ☐ Unknow	n	9□Unknown									
res that signed to be deta	by	Part II. Other sign	ificant conditions	contributing to death bu	ut not resu	lting in the u	nderlying cause giv	en in Part I		23e. Did to			the cause of death? bbably 4 □Unknown
w requir been si should	eted											<u>,</u>	
has t ge 2 s	Completed									24a. Was autor perfo		24b. Were au prior to death?	topsy findings available completion of cause of
	ပိ	25. Was case refe	erred to medical					26 Place	of Dooth /	1□ Yes Check only o	2 X No	1 ☐ Yes	2 No
_ × × ×	0 8	examiner? 1 ∐ Yes 2[∑	_	Hospital: 1 ☐ Inpatie	nt 2 🗆 E	R/Outpatier	nt 3 DOA Oth					6 ▼ Other (Spec	cify) hospice
ding Ph P. After th funeral	n: T	27. Manner of Dea	ath 5 Pending	28a. Date of Inju	ry / Year)	28b. Time o	f 28c. Injur Wor			d. Describe I			<i>ж</i> ноортее
tendii eath. For: A	catic	2 Accident	investigation					Yes 2					
or At after d Direct in by	Certification:	4 Homicide	data-minad		Iry - At hor c. (Specify	me, farm, str	eet, factory, office		28	f. Location (8 City or Tox	Street an vn, State	d Number or Ru)	ral Route Number,
le Hospital or Attendin 124 hours after death. In Funeral Director: Af bletely filled in by the fur		29a. Certifier		nysician: To the best									
To the Hosp within 24 ho To the Fund completely f	edical	(Check only one)		miner: On the basis of and manner sta	r examinati ited.	ion and/or in			ath occurred				
Veith To 1	Σ	29b. Signature and	d title of certifie	Lola -	\A		29c. Licens		1 / -:	_		te signed <i>(Monti</i> ember 2,	- '
		Buc	mure WI	and a second	Y}	000\ (T		164	615		ehre	ember 2,	2007
8/0		/		completed cause of do				ockvi	.11e.	MD 208	350		
Sta		31. Date filed (Mo.	onth, Day, Year)	32. Registra	ar's Signat	ure							
Regist	rar		SEP OF	2007 1000	140 -	K	hout i						

State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 30218 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William 09/05/2007 01:25P Ireland Henry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chestertown

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 06/10/1917 Chester River Manor Kent 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F 218-09-0925 90 **Director** Maryland Usual Residence of Decedent or 28a-f show be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 8931 Fairlee Road 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ▼No if Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic..... Elementary/Secondary (0-12) College (1-4or 5+) 8 Resident Maintenance Engineer | Road Development 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion Milton Ireland, SR ဥ Nellie Jacobs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Young Ireland wife 8931 Fairlee Road Chestertown, Maryland 21620
e of Disposition (Name of Date 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul's Cemetery Sept. 10 Chestertown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kuks Fellows, Helfenbein, & Newnam Funeral Home PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 12 heiner **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any lateng to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit end Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ē in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þ 1 🗆 Yes 2 **X**No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy death? 1 ☐ Yes 2 ☐ No certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 2 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending Natural 5 ☐ Pending investigation 1 TYes 2 TNo 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1055 in. 02 Susan ms 31. Date filed (Month, Day, Year) State SEP 0 Registrar

	ľ	For State Registrar		Marylar				ealth a Death	and M		Reg. No	2007	
Physicia /Medic Examin	al er	Decedent's Name (First, Middle, L Daniel Morris 4a. Facility Name (If not institution, g. Stella Maris	Jamison ive street and numi			T.	imon				ber 40	13, 200 c. County of De Baltin	07 8:20 T eath note
Funeral Director		5. Social Security Number 6. 215-58-0432 Usual Residence of Decedent	Sex 7 1 M 2 □ F	. Age (In yrs.	last birthday) Yrs.	If Unde Months	r 1 Year Days	if Under: Hours	24 Hrs. Min.	8. Date of Bi (Month, D. 04/07/	rth 1953	9. E 3 Ma	Birthplace (State or For Country) LYLUND
natural", or items 23a or 28a-f show dical Examiner must be notified at	rector	10a. State 10b. County MD Harford 10e. Street and Number	d	10c. Ci	ty, Town or Lo Havre						10a. Ci	itizen of What	10d. Inside City Li 1 Tyes 2 Country?
s 23a or	Funeral Director	141 Weber Stree	12. Was Deced	ont Ever in U	18 12		21078		gin? (Sn.	ooify Voo or N		u.s.	-
ral", or item	þ	11. Marital Status 1 ☐ Never Married 2 M Married 3 ☐ Widowed 4 ☐ Divorced	Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? R⊠No	- 1	if Yes, spe		Specify:	i, Puerto	ecify Yes or No Rican, etc.)		Black, W	
jiene. r than "natu the Medica	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4	4or 5+)	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u Bric	ork done d se retired	<i>luring</i> mos)	t of work	ing		Kind of Busines	·
and Mental Hygies s marked other t umatic event, th	To Be C	17. Father's Name (First, Middle, Las Cand Monnis Jam	ison		40- 14-9		(64	Mari	y Fr	cinces f	lutte	9	7.044
of Health and Item 27 is n other traun		19a. Informant's Name/Relationship Daniel M. Jamiso 20a. Method of Disposition	n, II (Sc	20b.		Blue	bill me of	Cowr	t, H		Gra	or Town, State CCe, MD cocation - City	
Department of Health and Mental Hygene. Important: or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	cify)	tate	. Ferri	S & (CoI	nc. (EL SI	mith Fu	ıneri	al Home	ter, PA
as been signed by the attending physician and 2 should be detached for use as the burial-transit	lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	r as a consecura as a consecura as a consecura as a consecura as a consecura as a consecura as a consecura as a consecura as a consecura as a consecurate as a	quence of):								
y the attending phiched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2☐Fetant at time of o	al death 3	⊒Ectopic p ☑ Other (s						23d. Date of o	delivery Day Yea
n signed by the a	۾	Part II. Other significant conditions	contributing to dea	ith but not res	sulting in the u	nderlying (cause give	en in Part I.					e to the cause of deat
ate h	Completed									24a. Was auto perf 1 Yes	opsy ormed?	prior t death	
s certific lirector,	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2] ER/Outpatier	nt 3□ D	OA Othe			h (Check only	one)		pecify) HOSPIC
nin 24 hours after death. the Funeral Director: After this certificate has npletely filled in by the funeral director, page 2	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not	28a. Date of (Month	Injury , Day Year)	28b. Time o Injury	f M	28c. Injur Worl		No	28d. Describe	how inju	ury occurred	Rural Route Number
ours after overal Direction by		4 ☐ Homicide determine	building	g, etc. (Speci	fy)			ne, date an		City or To	wn, Stai	te)	
within 24 hours after death. To the Funeral Director: / completely filled in by the fi	Medical		and manne	sis of examina		vestigatio	n, in my o	pinion, dea	ath occur	red at the time	, date ar	nd place, and o	
3 Sta	to	30. Name and address of person wh DR. TARIQ MAHM 31. Date filed (Month, Day, Year)	OOD 2300	,	EY VAL	Print)				MD 21	093	11 1/2	

SEPTEMBER 13, 2007 8:02 p.m.

Division or Vital Records, P.O. Box 68760, DANIEL JAMISON

ı			1 - For State Registrar	te of Maryland / Dep	ertificate of		nental Hyg ı	giene Reg. No. 20	07	3022
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Christian	Jansen	III		2. Date of Dea Month August	31 ^{Day} 200) Ž ^{ear}	3. Time of Death 3:00 P M
100	Exami	ner	4a. Facility Name (If not institution, give street a Anne Arundel Medical (nd number) Center	4b. City, Town, or Annapoli	r Location of Death		4c. County Anne		lel
	Funeral Director		5. Social Security Number 6. Sex 127-56-5409 1 M 2	□ F 7. Age (In yrs. last birthda 61 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day January	, 1946	9. Birthp Virgi	lace (State or Foreign try) Lnia
	e Maryland ta-f show tifled at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arunde	10c. City, Town or I					10	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with th 23a or 28 ast be no	al Director	10e. Street and Number 704 Riverview Terrace	2	10f. Zip Code 21401			10g. Citizen of V USA	What Coun	try?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married 1 1 If Y	s Decedent Ever in U.S. jed Forces? Yes 2 \(\sum \) No 1964— es, Give ar or Dates: 69	B. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp. an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America k, White, c Whit	etc.
21215-0036	within 72 ho liene. r than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade comp	leted) 16a. Dec (Giv. life. Presi	edent's Usual Occup. Ve kind of work done o DO NOT use retired Ldent	ation during most of work d)	ing	16b. Kind of Bu		ustry
Maryland 2	ould be filed Mental Hyg arked other atic event, i	To Be C	17. Father's Name (<i>First, Middle, Last</i>) Christian	Jansen, Jr.		18. Mother's Name Frances	(First, Middle, Helen	Maiden Surnam Bowlin	,	
, Mar	and 2 sho talth and 1.27 Is ma		19a. Informant's Name/Relationship (Type. Print Allen Carroll - Frier		ling Address <i>(Street a</i> Piscatawa					
Baltimore,	Pages 1 annent of He Int. If Item		20a. Method of Disposition 1 A Burial 2 □ Cremation 3 □ Remova 4 □ Donation 5 □ Other (Specify)	HOII State I.	oosition (Name of ematory or other plac Jemorial Park		Oate 007	20c. Location - Roanoke	-	
Balt	permit. Departr Importa any Inji		21. Signature of Funeral Service Licensee	6	Page 19 Address P. K 160 Oxon H	alas Fune				
	Physician /Medical Examiner			that caused the death. Do not en e on each line.	mter the mode of dying	g, such as cardiac o	or respiratory arr	rest,		Approximate Interval Between Onset and Death
68760,	tificate be executed ig physician and as the burial-transit	ledical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequence of): ue to (or as a consequence of):						
.O. Box	eath certi attending for use a	by Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)			23d. Dat Mor	e of deliver	y Day Year
rds, P	w requires that the d been signed by the should be detached		Part II. Other significant conditions contribution Coro houry On Fem 1	g to death but not resulting in the of	underlying cause give	en in Part I.	23e. Did tol			e cause of death?
Vital Records,		Completed	25. Was case referred to medical				24a. Was a autops perform	med? d 2 No 1	rior to com eath?	sy findings available apletion of cause of
	Physician: r this certific ral director, i	o Be	examiner? 1 Yes 2 No Hospital:	1 Anpatient 2 ☐ ER/Outpatie	ent 3 DOA Othe	26. Place of Death			r /Spaciful	
n o	ding Pt J. After th funeral	n: T	27. Manner of Death 28a. 1 Natural 5 ☐ Pending	Date of Injury (Month, Day Year) 28b. Time (Injury)	of 28c. Injury Work			ow injury occurre		
UIVISION	teath tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e.	Place of injury - At home, farm, st building, etc. <i>(Specify)</i>	M 1 □ Y	res 2□No	28f. Location (St City or Town	reet and Numbe n, State)	er or Rural	Route Number,
	o the Hospital or Ai vithin 24 hours after of the Funeral Direct oppletely filled in by	Medical C	E Incologi Examiner. On	To the best of my knowledge, dea the basis of examination and/or in manner stated.	th occurred at the tim	e, date and place, a binion, death occurr	and due to the cand at the time, d	ause(s) and ma ate and place, a	nner as sta	ited. the cause(s)
)	To the within 2	M	29b. Signature and title of certifier	ech, Mo	29c. License	number 46052	2	9d. Date signed	13110	ay, Year)
	A)		30. Name and address of person who completed	cause of death (Item 23a) (Type	Pronhway	anna	rolis 1	yp		
6	Sta Registr	te		32. Registrar's Signature	ريع					

Shirley Fay James State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Physician/ Month Day August 27, 2007 Shirley Faye Anderson James 1915 hrs dical Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Route 4 E.B. Donnell Drive Forestville Prince George's 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Washington Country) D.C. If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Director 578-64-3335 61 M 2XF Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No Maryland Prince Georges Forestville 28a-f show the Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20747 United States 6577 Hil-Mar Drive; Apt. 103 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes of No-14. Race - American Indian, Black; 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X No Yes Specify: Black 4 X Divorced If Yes. Give Year 1 Yes 2 X No specify: 3 Widowed à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages I and 2 should be filed within 72 hou. Department of Health and Mental Hygiene. Important: If item 27 is marked others injury or other trees. Completed during most of working life. DO NOT use retired) Howard University Elementary/Secondary (0-12) College (1-4 or 5+) Cashier Hospital 12th grade 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) James Britton Louise Rosemary Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town; State, Zip Code) 20716 19a. Informant's Name/Relationship (Type; Print) 16705 Governor Bridge Road; Apt. 107; Bowie, Maryland Sheila Lynn James (Daughter) 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 XXBurial Cremation 3 Removal from State Resurrection Cemetery Sept. 6,2007 Clinton, Maryland Donation 5 Other Specify 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc.
600 Kennedy Street, N.W.; Washington, D.C. 21. Signature of Funeral Service Licensee 20011 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED attending physician or use as the burial -Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene this 1 Yes 2 No 28a. Date of Injury (Month, Day Year) Aug 27, 2007 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Pedestrian struck by mortocycle 1 Natural 1909 hrs 1 Yes 2 ✔ No Pending Director: 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Suicide Could not be or Town, State) determined Pennsylvania Avenue, Forestville, MD (Specify) Major Road / Highway Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 28, 2007 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature SFP 0 6 2007 Registrar

ORIGINAL

OCME

DHMH 17 Rev 1/2001

OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend 28a-f, perME, g876 2/25/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** 2007 24 ODOR /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** WIJGRS14 Im SV If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign

Country) 7. Age (In vrs. last birthday Sex. 1X M 2□F **Funeral** Months Days NOII) Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or 28a-f show at 1 Yes 2 No Examiner must be notifled Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Nymbe 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 2XNo ٥ Baltimore, Maryland 21215-0036 1 ☐ Yes Specify Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 'natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 is marked other? 17. Father's Name (First, Middle Be ပ္ 19b. Mailing Address (Street and Nur. Town, State, Zip Code) or other Method of Disposition

1 ABurial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location Town, State 3 Removal from State Injury 5 ☐ Other (Specify) 22. Name Signature of Funeral Service Licens Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 3685 /Medical ALFOANOM APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Examiner NB Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician Physician/Medical for use If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Vear in the past 12 months? 5 Other (specify) □Yes 2□No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 □ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be (26. Place of Death (Check only one) Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 1 Natural 5 ☐ Pending investigation 1 ☐ Yes XX No 12/15/2006 unk 2 Accident Bile duct injury during surgery 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 I Director: within 24 hours

To the Funeral Dir

> State Registrar

Medical

29a. Certifier

31. Date filed (Month.

29b. Signature and title of certifier

Hospital

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

22 S. Greene St. Baltimore, MD

30. Name and address of person who ed cause of death (Item 23a) (Type, Print)

2007

s Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State of Maryland / Department of Health and Mental Hygienes of

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			1 - State Registrar	,	Cei	rtificate of	Death		Reg. No.	UUI	302	124
ſ,	Physici	an	Decedent's Name (First, Middle, Last)	-				2. Date of De	eath Day	Year	3. Time of	
	/Medic		John Lawrence Jones					Septemb	per 3	2007	9:33 1	А м
	Examir	ner	4a. Facility Name (If not institution, give street a				or Location of Death			unty of Death derick		
	· · · · · · · · · · · · · · · · · · ·		Frederick Memorial 5. Social Security Number 6. Sex		o at hirthdout	Frede		O Data of Bio		_		
	Funeral Director		216-28-1035 1 ^M M ²	7. Age (iii yis. ii		Months Days	Hours Min.	8. Date of Bir (Month, Da March	10,1931	Mar	pplace (State c intry) yland	r Foreign
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside Ci	tv Limits
	ne Maryi 8a-f sho otified at	ector	Maryland Carroll	1	Mount	Airy					1 ∐Yes	,
	th with the 23a or 2 ust be no	al Dire	10e. Street and Number 1120 Shaffersville	Road		10f. Zip Code 21771			10g. Citizen Unite	of What Cou	intry? ites	
	r dea	nel	11. Marital Status 12. Wa	s Decedent Ever in U.S ned Forces?	S. 13. V	Was Decedent of H	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No)- 14.	Race - Amer Black, White		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	If Y	Yes 2 No es, Give ar or Dates:	- 1	l∐Yes 2⊠ No		, , , , , , , , , , , , , , , , , , , ,		ec <i>ify:</i> Bla		
5-0	72 h 'natu dical	etec	15. Decedent's Education (Specify only highest grade comp	leted)	16a. Deced (Give	lent's Usual Occup kind of work done	pation during most of work d)	ing	16b. Kind o	of Business/Ir	ndustry	
121	d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than " traumatic event, the Med	ם	Elementary/Secondary (0-12) Col	lege (1-4or 5+)		00 NOT use retire 1 Bus Dr			Desire	t - C - 1	7	
2	iled v Hygie Iher t	ပိ	17. Father's Name (First, Middle, Last)		301100.	L Dus Dr.	18. Mother's Name	o /Eirot Middlo		te Sch	1001	
au	d be familial led or	Be	Frank	Jones			Cather			Henson		
Ž	should nd Me mark matic	မှ	19a. Informant's Name/Relationship (Type. Print		19h Mailin	n Address (Street	and Number or Run					
Ma	nd 2 s Iffh ar 27 Is 1 trau		Amy Jones / Daughter				sville Rd					771
ē,	tem Thea other		20a. Method of Disposition	20b. Pl		sition (Name of natory or other pla		Date		on - City or T		//1
Baltimore,	Pages ent of nt: If I		1 XBurial 2 □ Cremation 3 □ Remova 4 □ Donation 5 □ Other (Specify)	i irom State			ery 09/07	/2007	Don lar	a Comi	nos MT	1
Ħ	nit. Frartmoortan		21. Signature of Funeral Service Licensee) Dim	22	. Name and Addre	ess of Facility Sta	/200/	Funera	1 Home	ngs, M	,
ñ	permi Depar Impor any ir		Do mon Orale	Da est			sumtown Pi					
			23a. Part1 Enter the disease, or complications shook or heart failure. List only one caus	that caused the death					_		Approximate	е
	Physician		Innered None (Fig.)		0	م ' ، ، ملا ،					Onset and I	Death
1	/Medical		resulting in death)	Cordiac Due to (or as a consequ	ence of):	Trimia						
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	ecute ind trans	Examiner	that inhated events									
30,	oe exe cian a urial-		resulting in death) Last	ue to (or as a consequ	ence of):							
68760,	rificate be executed ig physician and as the burial-transit	Medical	d	***************************************								
9 ×	pertification of the seas		IF FEMALE: 23c If w	es, outcome pf pregnar	nev							
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/	in the past 12 months?	lLive birth 2 ☐ Fetal Pregnant at time of de Unknown	death 3 [lEctopic pregnanc l Other <i>(specify)</i> _	у		23d.	Date of delive	•	⁄ear
	s that ned b deta		Part II. Other significant conditions contribution	g to death but not resu	Iting in the un	derlying cause giv	ven in Part I.	23e. Did t	obacco use c	ontribute to	the cause of d	eath?
or Vital Records,	quire n sig uld be	ed by						10	Yes 2√N	o 3□Pro	bably 4 □U	Jnknown
000	s bee	Completed						24a. Was	an 24	4b. Were aut	opsy findings a	available
R	The lay	шо					•		psy prmed?	prior to co death?	ompletion of ca	ause of
ital		0	25. Was case referred to medical				26. Place of Deatl	1 Yes	2Mo	1 ☐ Yes	2□ No	
\ \	dir dir	To B	examiner? 1 Yes 2 No Hospital	1 Mpatient 2 ☐ 8	ER/Outpatient	t 3 DOA Oth				Other (Spec	ifv)	
0	ng Ph ter th neral			Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Describe I			-57	
<u>i</u>	Attending r death. ector: After by the funer	atio	2 ☐ Accident investigation	(, 2 - 3,)	,,		Yes 2 □ No					
Division	or Attending I after death. Director: After in by the funer	Certification:	3 Suicide 6 Could not be determined 28e.	Place of injury - At hor building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (\$ City or Tox		ımber or Rur	al Route Num	ber,
	ital c											
	To the Hospital or Atter within 24 hours after de To the Funeral Direct completely filled in by th	edical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: 2 ✓ Medical Examiner: Or an	To the best of my know the basis of examinati d manner stated.	vledge, death ion and/or inv	estigation, in my	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and date and pla	manner as s	stated. to the cause(s)
	To t To t	Ž	29b. Signature and title of certifier		-	29c. Licens			29d. Date sig			
			Mors legalle	hams M	·D	DOC	64741		9/	4/07	7	
Ç	5+1		30. Name and address of person who complete	d cause of death (Item	23a) (Type, F	Print)	11 - 1 -	,				
	Cin	10	31. Date filed (Month, Day, Year)	32. Registre's Signat	ure M	money	Mospited	, tree	enck	MU		
	Sta Registr		Misy Leign William 31. Date filed (Month, Dd, Year) SEP 0 7 20	07 > Seem	, J	Species						

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2007

30225

				Certificate of	f Death	R	eg. No.	
		1. Decedent's Name (First, Middle, Las	st)			2. Date of Dea Month		3. Time of Death
	Physician	Linaries Ern	est Joi	nes		Septemb	er 10, 200	7 3:38 AM
	/Medical Examiner	An English Bloom /// and innelled an air	e street and number)		4b. City, Town, or	Location of Death	4c. County of De	ath
	_xammer	11620 CherryTree	Crossing Road	d	Brandywi	ne	Prince (George's
	Funeral	5. Social Security Number 6. S		last birthday) If Under 1 Yea		8. Date of Birth (Month, Day	9. B	hirthplace (State or Foreign Country)
	Director	214-52-4100	M 2□F 57	Yrs. Months Day	s Hours Will.	Oct. 16	,1949 Was	shington, DC
	TQ.	Usuel Residence of Decedent						
	rylen how	10a. State 10b. County	10c. Cit	ty, Town or Location				10d. Inside City Limits
	a Ma	Maryland Prince G	George's	Brandywine				1 ☐ Yes 2基 No
	vith the Ma	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What (Country?
	th wi		Crossing Road	2061	.3		USA	
	n 72 hours after death with the Maryland *naturel*, or items 23a or 28a-f show e-Sical Examiner must be notified at lieted by Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	,S. 13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
0	after or the		1 ☐ Yes 22∰XNo If Yes, Give	1 ☐ Yes 2 【XN			Specific	
21215-0020	ours a	3 Widowed 4 Divorced	Year or Dates:					White
5	ed within 72 hoygiene. Ner than "nature It, the Medical	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16e. Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	upation e <i>during most of wor</i>	king	16b. Kind of Busines	s/Industry
2	d within giene.	Elementary/Secondary (0-12)	College (1-4or 5+)				Commercia Co	overnment
2	Hygien that the that the that the that the that the that the the that the that the the the the the the the the the th	10		Mechani		ne (First, Middle, I		Jveriment
E C	be filed d other event,	17. Father's Name (First, Middle, Last)		Tama a				lings
\frac{1}{2}		•	М.	Jones	Margare			
Maryland	2 6 8 6	19a. Informant's Name/Relationship (7	***************************************	19b. Mailing Addrass (Stre				
	C 76 01 1-	Frances Jones/ Sp			Tree Cros			ine, MD20613
9	as to L	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Damauel from State	Place of Disposition (Name of cemetery, crematory or other p			20c. Location - City of	
Baltimore,	Pa jir jir	4 ☐ Donation 5 ☐ Other (Specify		insfield-Echo	Is Crm.	9/14/07	Charlott	e Hall, MD
at	permit. Departr Imports any Inju	21. Signature of Funeral Service Licen	500 / /	22. Name and Add		Funoral I	Jama D A	
ш	20 = 20	Dunta C	Chil TR M008:	17 30195 Thr	ee Notch	Rd., Cha	Home, P.A. rlotte Hal	1, MD 20622
	4	23a. Part1. Enter the/disease, or comp shock, or heart failure. List only	plications that caused the deat	h. Do not enter the mode of d	ying, such as cardiad	or respiratory arr	est,	Approximate Interval Between
- Star	Physician	Shock, of fleat failure. List only	one cause on each line.					Onset and Death
market.	/Medical	Immediate Cause (Final disease or condition	Idionathi	ic Fibrosing A	lveolitic			
ni.	Examiner	resulting in death)		or as a consequence of):	TACOTICES			
	certificate be assecuted diging physician and isa as the burial-transit	Sequentially list conditions.	b. — Due to (o	or as a consequence of):				
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68760,	ficata ba physicia as the bur	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or	r as a consequence of):				†
89	ug ph as th	resulting in death) Last						
Box			d					+
	death of attended for u	Part II. Other significant conditions co	ontributing to death but not resu	ulting in the underlying cause g	given in Part I.	23b. Did to	bacco use contribu	te to the cause of death?
P.0	v requiras that tha death obeen signed by the attenshould be datached for u letted by Physiciar	•				1 🗆 Y	s 2 X No 3□	Probably 4 Unknown
	as tha igned be da			91 WY .				
5	quira an sig ould to					24a. Was a		. Were autopsy findings available prior to
ပ္သ	law relias becare							completion of cause of death?
of Vital Records,	a - 5 =					1 □ Ye	es 2 No	1 ☐ Yes 2 ☐ No
ta	certificata ractor, pag	25. Was case referred to medical			26. Place of Dea	ith (Check only on	e)	
>	Physician: r this certificated director,	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3□ DOA C	Whor:	1.	ence 6 Other (Sp	pecify)
0	orthis eral	27. Manner of Death	28a. Date of Injury	28b. Time of 28c. Inj			ow injury occurred	
9	th. : Afte	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		Yes 2 No			
Division	Attending or death. Sctor: After by the fune	3 ☐ Suicide 6 ☐ Could not be	286. Place of Injury - At hu	ome, farm, street, factory, office	Ð		reet and Number or	Rural Route Number,
ă	tal or Attending P rs efter death. el Director: After t led in by the funers Certification:	4 Homicide	building, etc. (Specify	Y)		City or Towr	i, State/	
		29a. Certifier 1 Certifying Phy	ysician: To the best of my know	wledge, death occurred at the	tima, date and place	, and due to the ca	ause(s) and manner	as stetad.
	n 24 hour ne Funer Pietely fil	(Check only 2 Medical Exam	iner: On the basis of examinat and manner stated.	tion and/or investigation, in my	opinion, death occu	rred at the time, di	ate and place, and di	te to the cause(s)
	within 2 To the comple	29b. Signature and title of certifier	A		nse number		9d. Date signed (Mo	
	ι λ	1 Am	1	nin	12335	42	9-12	-07
	10,00	30. Name and audiress of person who g	ompleted cause of death (Item	23a) (Type, Print)	, 2000	9		
	1 00	Cameron Mes	11 920	0/0 0 23e) (Type, Print) 0 Bas, Cf ture	- Largo	mo.	20774	
1	State	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture	0			
No.	Registrar	SEP 1 4 20	ا الم	K Should				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 2, 2007 **Physician** 11:30 AM Wilson Alfred Jefferson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis Anne Arundel Genesis Eldercare Spa Creek Center If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Min. **X**X M 2□ F Davs Oct. 16, 1918 Director 214-05-1351 88 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "national any injury or other than "national". 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County XXYes 2 □ No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States Funeral 206 Glen Ave. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes ZNNo If Yes, Give Year or Dates: 1 ☐ Never Married XX Married White 1 □ Yes XX No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lumber Yard 12 Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Alfred Jefferson Bessie Popham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 206 Glen Ave. Annapolis, Maryland 21401 Evelyn F. Jefferson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Cedar Bluff Cemetery 9/6/2007 Annapolis, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) N Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy rmee 2∐No 1□ Yes within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner 1 TYes 2 0 1 Inpatient 4 rsing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Injury at Work? (Month, Day Year) Injury 1 Matural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi 632036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) No Donal Dim Chester Mis 2/6/9 50 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 0 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30227 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sept **EVA ELIZABETH JONES** IO: IZAM 04, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memoria tospital Talbot 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1□M 2XF Hours Director 218-18-0526 84 MAY 12, 1923 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 Yes 2 No MARYLAND OUEEN ANNE'S **QUEEN ANNE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14071 SADDLE BACK LANE 21657 Funeral UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. HOMEMAKER 12 OWN HOME permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, If 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OSCAR LEON DADDS ANNETTE ISABELL DELACY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRIET SMITH / DAUGHTER 14071 SADDLE BACK LANE, QUEEN ANNE, MARYLAND 21657 altimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State SEPTEMBER 1 X Burial 2 ☐ Cremation 3 Removal from State 5 Other (Specify) STEVENSVILLE CEMETERY 10, 2007 STEVENSVILLE, MARYLAND 21. Signature of uneral Service Lie FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Ellies the disease, or composhock, or heart failure. List only o Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Physician AMERY DISBASK OCANACY resulting in death) /Medical Examine Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed attending physician and for use as the bunal-transit that initiated events resulting in death) Last Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 No Month Day Year P.O. | 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tyes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy page certificate 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 🗌 Inpatient 2 ■ ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 1 M Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

or Vital Division To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu P

Jone

Eva

State Registrar

31. Date filed (Month, Day, Year) 5 0

29b. Signature and title of certifier

30. Name and address of person who con

use of death (Item 23a) (Type, Print)

205 Medical Center Road, Grasonville, MD 21638

29c. License number

027055

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 4 2007 **Physician** 12:34am artha Jones /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Dorchester Cambridge Dorchester General 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔽 F Days Hours Min. Director 220-10-6142 Usual Residence of Decedent Apr: 1 12,1917 Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 Nes 2 No Director hester 10e. Street and Number 10g. Citizen of What Country? Brad 21613 £4 by Funeral U.S A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: Black 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and 2 should be filed withi salth and Mental Hygiene. Processing Food is marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Hicks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pilarin Road Baltimore, MD. Seymore 6208 tanes 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 → Burial 2 □ Cremation 3 □ Removal from State 18/07 Cemetery ethel 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD. 22. Name and Address Facility
HENRY FUNERAL HOME, P.A.
510 Washington St. Cambridge 21. Signature of Funeral Service Licensee 23a. Party Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 yes /Medical Due to (or & a consequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-tran Due to (or as a consequence of): attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Por Month 4□Pregnant at time of death Day Year 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of : After I 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

the death certificate be executed Box 68760. P.0. Records, or Vital Physician: or Attending

Baltimore, Maryland 21215-0036

completely filled in by the funeral director, within 24 hours after death To the Funeral Director:

> State Registrar

Medical

29a. Certifier (Check only one)

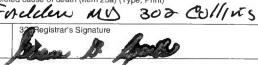
31. Date filed (Month, Day, Year)

MichaelJ

29b. Signature and title of certifier

SEP 06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

State of Maryland / Department of Health and Mental Hygiene 007 30229 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPT. 15, 2007 KATHEY MARIE KRZYWDA 4:50A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2036 ALEHOUSE COURT WALDORF CHARLES If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9 – 23 – 1956 9. Birthplace (State or Foreign Country)
N • Y • **Funeral** Months 1 □ M 2 🖫 F 092-50-6145 50 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location r than "naturel", or Items 23a or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2√2 No MD. CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2036 ALEHOUSE COURT 20602 Funerai U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Tes 2 1 Never Married 2 Married 2 - No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ğ 3 Widowed 4 Divorced Specify: WHITE Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Importent: If item 27 is marked other the eny injury or other treumetic event, the 2008. SECURITY MANAGER SAIC CORP 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be REGINALD MINER 2 IDA MAE TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID KRZYWDA-SPOUSE 2036 ALEHOUSE CT. WALDORF, MD. 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State OAKWOOD CEMETERY 9-22-07 • 4 □Donation 5 □ Other (Specify) SYRACUSE, N.Y. 21. Signature of Foreral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SE LA PLATA, MD. 20646 SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breast **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, fary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offe Examiner The law requires that the death certificate be executed Due to (or as a consequence of). Box 68760, Completed by Physician/Medical as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ö in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Donknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 ☐ Yes 2 ☐ No or Attending Physicien: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 ☐ Nursing Home 5 ★ esidence 6 ☐ Other (Specify)
Injury at 28d. D. cribe how injury occurred Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 1. Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No death in by the 1 Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide within 24 hours a To the Funerel C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person 5 who completed cause of death (Item 23a) (Type, Print) 170 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30230 1- State Registrar Amend #5 Per FH G872 10/01/02 rtillicate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Mary Madeline Kerns <u>September 09,2007</u> 9:20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 209-28 × 8015 **Funeral** Days Months 1 M 2 XF Hours May 11,1936 Director PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene.
Instit if item 27 is marked other than "natural", or items 23a or 28a-f show ant; if item 27 is marked other than "natural", or items 25a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ No Director MD Washington Hancock 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 153 B West Main Street 21750 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ (M)No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Housekeeper</u> 6 Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Crawford Goldie Walls 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Melvin E. Kerns/Husband 153 B West Main Street Hancock, MD 21750

ce of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 09/11/2007 Smithsburg, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. ter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has page 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 □ DOA ٩ 1 Impatient 2 ER/Outpatient 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 Yes 2 No investigation 2 Accident Director: 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

0 2007

30 Name and address of person who

31. Date filed (Month, Day,

cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SEPTEMBER 02, 2007 7:06A M DORSIE B. KELLY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months 1 □ M 🐰 F JULY 07, 1925 ROANOKE, VA Director 359 22 0369 82 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County works ä Yes 2□No notified Director MD PRINCE GEORGES SUITLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Examiner must be UNITED STATES 20746 4224 SUITLAND ROAD or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. within 72 hours after 1 ☐ Yes 2XXVo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify: \$ Specify: BLACK 3√Widowed 4 □ Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 sh. uld be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than MEDICAL 1+ NURSE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIE MAE DAVIS ALBERT DEBOISE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTINSBURG, WV 25401 THOMAS JOHNSON, JR. / SON 510 BUTLER AVE. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition MXBurial 2 ☐ Cremation 3 ☐ Removal from State 6 injury RESURRECTION CEMETERY 09/07/2007 4 ☐ Donation 5 ☐ Other (Specify) CLINTON, MD 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND 21. Signature of Funeral Service Licensee INC. 'n SUITLAND, MD 20746 4308 SUITLAND ROAD Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. show gears Immedia Cause (Final Cardiovascular Diseas **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 Tyes 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No r death. 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0028429 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Phyllis Nichalson, MD 18101 Prince Phillip Drive Olary, Maryland 20832 32. Registrar's Signat State 0 6 2007 Registrar

amend line 4b per phy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 9/05/07 dlw State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 2 Cay **Physician** 5:05 P M 8 7005 /Medical Deale 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Deatl Examiner 41 Anne Anna 5989 Beach If Under 1 Year | If Under 24 Hrs. 3. Date of Birth (Month, Day, Year) 03/31/1928 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Min Hours 1 □ M 2453cF 212-24-7389 79 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show MD Anne Arundel Deale 1 TYes XXNo 7 is marked other than "natural", or items 23a or 28a-f sl traumatic event, the Medical Examiner must be notified Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 5989 4th St. 20751 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No White Specify. ģ Specify: 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookeeper Car Dealer h and Mental Hygien 7 is marked other to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be Helen Burdette Alvie Eugene Franklin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau 20751 5989 4th St. Deale, MD Ricky Kent Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 9/1/2007 Metro Crematory Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Se lice Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Valne 12 Ridgely Ave. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** month /Medical Due to (or as a cons dence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the SS IF FEMALE nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 pronths? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ò 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate I 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2D No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 ER/Outpatient 3 DOA ို 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After Injury Natural 5 Pending investigation 1 Yes 2 No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) ss of person who 32. Reistrar's Signature 31. Date filed (Month, Day, Year) State 0 5 2007 Registrar

Amend item#24a&26 per Kristen Forster.verbal,09/12/07.WCHD,slu Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier 001

1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Rebecca Morris Kleisch August 31, 2007 0630 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 610 Fountain Road Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 218-24-4086 1 ☐ M 2 🕱 F Yrs. Director 78 12/8/1928 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Itame 23a 610 Fountain Road 21801 USA death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specify: Completed by Specify: white 3 Widowed 4 Divorced "natural", 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Reese W. Morris Helen Mills 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 Is eny injury or other tre QDCE. William Kleisch/husband 610 Fountain Rd., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Salisbury Crematory 9/4/07 Salisbury, MD 21. Signature of Funeral Service Licensee THOITOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TROKE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Abrilanon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner attending physician and for use es the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□ Unknown 9 Unknown page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospitel or Attending Physicien: After this certification funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) ပ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation М 1 Yes 2 No hours after death 2 Accident Director: 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D0050614 MI who completed cause of death (Item 23a) (Type, Print) 0. Name and address of person Pensem Dr Sute 101 ewang Sch & bury 1205 31. Date filed (Month, Day,) 32. Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 09:25 AM nal d xotember 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Manjand Medical Center TIMOVE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number () 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 225-90-9481 50 JUNE 15,1957 **Director** VIRGINIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If Item 27 is marked other than "hatural", or items 23a or 28a-f show ant: If Item 27 is marked other than "hatural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notitied at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 □ No Director MD Prince George DISTRICT HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2220 ROSLYN AVE 20747 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 3yrs Elementary/Secondary (0-12) PRIVATE DIRECTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES L. LONG ESTELLE JENNINGS ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROXIE JONES/WIFE 2220 ROSLYN AVE DISTRICT HEIGHTS, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of Inportant: If Ite
any Injury or of ₩ Burial 2 Cremation 3 Removal from State HARMONY MEMORIAL 09-10-2007 | LANDOVER, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service License 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metustatic Dancicatio /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed led by the attending physician and detached for use as the buriat-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should? Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an performed2 es 2 X No 1☐ Yes Hospital or Attending Physician: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပို 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sandra Que zada M.D. South

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

0 6 2007

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year Physician SEPTEMBER 02, 2007 4:45P BERTHA TATE LESTER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HYATTSVILLE PRINCE GEORGES SAINT THOMAS MORE NURSING & REHAB If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** 1 □ M 🗶 💢 F 1947 | MISSISSIPPI 587 48 0446 JAN. 07, Director 60 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 'natural', or items 23a or 28a-f show other traumatic event, the M-dical Examiner must be notified at XXYes 2 □ No Director PRINCE GEORGES HYATTSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20785 UNITED STATES 4922 LaSALLE ROAD death Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes XX No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes XX No Specify. ģ XX Widowed 4 Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 12TH HOUSEKEEPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BERTHA ROBINSON FRANK TATE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CORETTA PRESSLEY / COUSIN 10700 FORESTGATE PL. GLENN DALE, MD 20769 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or conce. XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/11/2007 BROOKSVILLE, MS CHURCH CEMETERY 21. Signature of Fungral Service Licer 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Arter victeratic Cardiovasculus **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1□ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 □ Yes 2 □ No filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QUEENSBURY Rd GRATTSVILLEMB 20781 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 6 2007 Registrar

State of Maryland / Department of Health and M	lental Hygier	2007

30236 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** James Earl Lint September 4, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caroline Denton Caroline Nursing Home, Inc. If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2 □ F Yrs. Director March 31.1935 Pennsylvania 172-28-2304
Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Mudical Exercitive court be notified at 1 Yes 2 No Directo Denton Maryland Caroling 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 21629 United States of America or Items 23a 26570 Burrsville Road death Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: þ Specify: Caucasian 3 Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) Coltege (1-4or 5+) pernit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other traumatic event. If a Mental File Mental Control of the Mental Control of Section 1 and Mental Control of S Republic Steel 12 Steel Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Huffine 2 Earl Lint 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 26570 Burrsville Road, Denton, Maryland 21629 Wife Betty J. Lint 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dawson, Pennsylvania 9/7/2007 Cochran Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21. Signature of Funeral Service Lice andoph bore 21629 23a. Part1. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Division of Vital Records. 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this matter. 25. Was case referred to medical examiner?

1
Yes

2 No Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٥ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Medical Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nes 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** CONSTANCE LABASH SEPTEMBER 5, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 D 1926 81 July 15, 095-20-9809 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 ☐ No Frederick Director Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number within 72 hours after death with 5500 Hayloft Court 21703 United States Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ MO Baltimore, Maryland 21215-0036 White Specify: 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 honent of Health and Mental Hygiene.
ant: If item 27 is marked other than "naturary or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Graphic Artist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stephanie Cantor John C. Bialas 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5500 Hayloft Court Frederick, Maryland 21703 James Labash / Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot Boyds Presbyterian 1 Burial 2 □ Cremation 3 □ Removal from State September Boyds, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 7, 2007 22. Name and Address of Facility Hilton Funeral Home 21. Signature of Funeral Service Licensee P.O. Box 86, Barnesville, Maryland 20838 Hilton 23a. fail. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mode, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Examiner rivato Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ranguence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ Yo 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2□ No 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**N**0 1 Inpatient 1 ☐ Yes Medical Certification: To 27. Mann of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 TYes 2 □ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21701 400 W. Seventh Street Frederick, Maryland 31. Date filed (Month, Day, Year) State SEP 0 7 2007

Registrar

07-07114 Vincent McCusker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ncent McCuske	1	- For State	ate of Maryl		rtment of tificate of		d Mental H		20	07 30238	
Physicia		t egistrar 1. Decedent's Name (First, Midd						2. Date of Death		3. Time of Death	
edical Examin	er	Vincent Jol						Month September		1138 hrs	
		4a. Facility Name (if not institution 3406 Western Pike	on, give street and n	umber)	4	b. City, Town, or Hancock	Location of Death	1	4c. County of De Washingtor		
	4	5. Social Security Number	6. Sex	7. Age (in yrs. la	ast birthday)	If Under 1 Yea	r If Under 24Hrs	s. 8. Date of Birth	(MM/DD/YYYY) 9.	Birthplace (State or	
Funeral Director	- 1		1 X M 2 F			Months Days	s Hours Mir	_	Fo	reign Country) PA	
		213-21-0453 Usual Residence of Decedent	X M Z F		20 Yrs.			pepualite			
····· · · · · · · · · · · · · · · · ·	🛏	10a. State 10b. County		10c. City,	Town or Location	on				10d. Inside City Limits	
Maryland 28a-f show any 1 at once.	7	MD Washi	ngton	Ha	ncock					1 Yes 2 X No	
Maryla 28a-f	Director	10e. Street and Number				10f. Zip Code			g. Citizen of What (Country?	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.		3513 National				21750			USA	mariana Indian Plack	
t be n	Funeral	11. Marital Status 1 X Never Married 2 N		ecedent Ever in U. Forces?	.S. 13. Wa	s Decedent of His es, specify Cubar	spanic Origin? (S n, Mexican, Puert	Specify Yes or No- o Rican, etc.)	White, et	merican Indian, Black, ·	
or deat	필		1 Yes	2 X No	1	Yes 2X No	specify:		Specify:	White	
ural",	à.	15. Decedent's Education (Sp	or Dates:		16a. Deceden	t's Usual Occupa	tion (Give kind of	work done	16b. Kind of Busine		
2 hou "nat	Completed	Elementary/Secondary (0-12		(1-4 or 5+)			e. DO NOT use re	tired)			
036 rthin 7 ne.	dr	12			La	borer				ruction	
5-0036 Ted within 72 hour. Hygiene. d other than "natu		17. Father's Name (First, Middle	e, Last)					ne (First, Middle, M			
2121 2121 ould be fil I Mental I marked ic event,	B	Robert C. McC	usker		I 10h Mailine	Address (Stro	Susan	Lee Rems	burg ber, City or Town, S	State, Zip Code)	
e, MD 2121 I and 2 should be f Heafth and Mental item 27 is marken r traumatic event	-	19aInformant's Name/Relation Robert C. McCu		dfather				ancock,M			
Zath Zath	-	20a, Method of Disposition	SKEL/ GLAII	20b.	Place of Dispos	ition (Name of ce		Date	20c. Location - Cit	y or Town, State	
Baltimore, permit: Pages I a Department of He Important: If ite		1 X Burial 2 Crematic	on 3 Removal	Irom State	crematory or ot		n ha/	18/2007	Hancock,	MD	
Baltimore permit, Pages 1 Department of 1 Important: If	. 4	4 Donation 5 Other 21. Signature of Funeral Service	Specify:	الالا	100.4	esbyteria	a of English		The second second		
Bal Depar Impo	4	21. Signature of Furnada Service	Place	4.4	Gro	we Fune	ral Home	P.A. F	West Mair Mancock,MI	Street	
Physician	\neg	23a. Part I. Enter the disease,	or complications that	caused the death	n. Do not enter t	he mode of dying	, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and	
'Medical	10	failure. List only one caus Immediate Cause (Final disease	1-41	gunshot woun	d					Death	
xaminer		or condition resulting in death)		a consequence of							
		Sequentially list conditions,	b		-f).		_				
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149. =	хап	(Disease or injury that initiated events resulting in death) Las	Due to (or as	a consequence of	of):						
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Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physici page 2 should be detached for use as the burn	ian/Me	IF FEMALE: 23b. Was decedent pregnant in	46 -	s, outcome of pro e birth	mancy	50	Ectopic preg	nancy	23d. Date of de Month	Day Year	
certif	ciar	past 12 months?		gnant at time of d		ther (Specify)				80	
Box 6 le death cer the attendi	ysici	1 Yes 2 No 9 L	3 011.	known							
P.O.	y Phy	Part II. Other significant cond	ditions contributing	g to death but not	resulting in the	underlying cause	given in Part I.	1		re to the cause of death? Probably 4 Unknown	
rds, P.C.	d by							24a. Was		ere autopsy findings available	
of Vital Records, g Physician: The law requii after this certificate has been s neral director, page 2 should	ompleted							auto	osy prio	or to completion of cause of ath?	
he law ate has age 2 sh	luo									Yes 2 No	
tal Rec cian: The certificate ector, page	e C	25. Was case referred to medi				26.Pla	ce of Death (Chec				
f Vital Physician: er this certif	O B	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatien			sing Home 5	Residence 6		
	ī.	27. Manner of Death 1 Natural 5 P.	EO(M)	ate of Injury onth, Day,Year) ND:	28b. Time of FOUND:		jury at Work? Yes 2 ✓ No	Subject sho	how injury occurred ot self		
Sior Attend r death. ector: by the	atic		Sep 1	13, 2007	1030 hrs			20f Location	Street and Number	or Rural Route Number, City	
. 2 부 등 수 년	Certification:		ould not be	lace of Injury - At	nome, tarm, stre	eet, ractory, onice	building, etc.	or Town.	State) n Pike, Hancock		
in a la		4 Homicide	Physician: To the	ify) Woods	d-+ de-th opp	ured at the time	data and place a				
To the Hos within 24 h To the Fur	ical	(Check only 1 Certifying one) 2 Medical E	xaminer:On the bas	sis of examination	and/or investig	ation, in my opini	on, death occurre	d at the time, date	and place, and due	to the cause(s)	
To t with To t	Medical	29b. Signature and title of cert	and manne	er stated.			nse number			(Month, Day, Year)	
	_	(TRIM				0.0	C.M.E.		September 1	14, 2007	
		30. Name and address of pers	on who completed o	ause of death (Ite	m 23a)						
6			ssistant Medica		111 Penn	Street, Baltin	nore, MD 212	201			
	tate	31. Date filed (Month, Day, Ye		Registrar's Signa		ab 1					
Regis			0 2007	Kalva 1	C. 600	MIL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 2007

			1 = For State Registrar		State of	maryiai		artment of I <i>rtificate of</i>				ie <u>Ze U U</u>	1 3	30239
-	Physic /Medi		1. Decedent's Name (First, M		MAT	THEU	u S		-	2.	Date of Death Month	n Day Y	ear	3. Time of Death
	Exami		4a. Facility Name (If not insti Washington A		e street and numb	ber)		4b. City, Town, o Takoma		of Death		4c. County of Montgo	Death	
100 M	Funeral Director		5. Social Security Number 216-60-4478		ex 7 M 2□ F	. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		Date of Birth (Month, Day Pt 27	Year 1953	Birthpla Countr Wast	ace (State or Foreign lington, D(
	aryland ahow	3-4	Usual Residence of Deceder 10a. State 10b. Co	unty			city, Town or Lo						100	d. Inside City Limits
	Ba-1	Director		ince	George's	3	Hyatts							1 Yes 2 No
	ath with t	rai Dire	10e. Street and Number	t Ro	ad #A6			10f. Zip Code 20783			10	og. Citizen of What United		*
980	72 hours after death with the Maryland natural', or items 23a or 28a-1 ahow alical Examilian to notitied at	by Funerai	11. Marital Status 1 孫 Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo		12. Was Deced Armed Forc 1 Tes 2 If Yes, Give Year or Date	es? Mo		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ♣ No			y Yes or No- can, etc.)	14. Race - Black, Specify:	Americar White, et	tc.
Maryland 21215-0036	within ane. Ihan	Completed	15. Dec (Specify only h Elementary/Secondary (0- 12 years		ducation de completed) Colfege (1-4	lor 5+)		dent's Usual Occup kind of work done DO NOT use retire				6b. Kind of Busin	bb. Kind of Business/Industry	
d 2	il Hygie other ont, II	Be Co	17. Father's Name (First, Mic	Idle, Last)			0		,			laiden Sumame)		
/lan	should be nd Mental marked o	To B	William Mat	hews	, Sr.				M	ary E.	Kosh			
Jan	2 should and Men is marke raumatic		19a. Informant's Name/Rela	ionship (7	Type, Print)		19b. Mailir	ng Address (Street	and Numbe	er or Rural R	Route Number,	City or Town, Sta	ate, Zip C	code)
	s 1 and 2 should be filed if Health and Mental Hyg item 27 is marked otha othar traumatic event,		Pamela Faye 1 20a. Method of Disposition	Field	s - Daug			Jib St. sition (Name of matory or other pla		Laurel Date	The second second	0707 Oc. Location - Cit	tv or Tow	n. State
E	Pages nent of int: If i		1 Burial 2 ☐ Cremal 4 ☐ Donation 5 ☐ Other			410		natory or other pla		Cont		7 Washi		
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot ance.		21. Sign ture of Funeral Ser	vije Li	500	- F		. Name and Addre	ss of Facilit			neral Ho		
Sign.	20 E 6 9		23a. Part1. Enter the diseas	J. I	olications that cau	Column dea	The Do not ent	001 Benni	ng Ro	ad, NE	E Washi	ngton, I		0019 Approximate
	Physician /Medical		shock, of heart failure. Immediate Cause (Final disease or condition resulting in death)	List only	a. Supe	in line.	lena C	our the			езриаюту апе	5 t,	1	interval Between Onset and Death
*	Examiner		Conventially that any distance		Due to (or	as a conse	quence of):							
	outed ansit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1	O) of euc	as a consec	цивнсв он.							
90,	ificate be executed g physician and as the burial-transit	I Ex	resulting in death) Last	118	Due to (or	as a consec	quence of):							
68760,	icate b physic s the b	ledical			d									
P.O. Box (Attending Physician: The law requires that the death certificate be executed refath. coath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outco 1 □ Live birtl 4 □ Pregnan 9 □ Unknow	h 2∏Feta ntat time of o	af death 3	Ectopic pregnancy	/			23d. Date of Month		y Day Year
	ires that signed b	by PI	Part II. Other significant con	ditions co	ontributing to deat	th but not res	sulting in the ur	nderlying cause giv	en in Part I.			acco use contribu		
Sorc	w requir been s should	eted	HIV /ADS	2	0)		10 1				21		bly 4 Unknown
Vital Records,	hysician: The law his certificate has I I director, page 2 s	Completed	Hutherte	has	Renal A	Liseon	l an	se aug	5		24a. Was an autopsy perform 1 Yes 2	ed? prio	r to comp	sy findings available pletion of cause of
Ę	/sicia s certi	To Be	25. Was referred to me examiner? 1 ☐ Yes 2 ☒ No	- 1	Hospitaf: 1 🛣 Inp	atient 2] ER/Outpatien	Oth			heck only one	nce 6 Other	(C===+.)	
n o	ng Phys Iter this neral di	T: no	27. Manner of Death 1 ⊠Natural 5 □ Pe	endina	28a. Date of		28b. Time of Injury					v injury occurred	<i>эрвспу)</i>	
Division of	itendir death. tor: Ai the fu	catic	2 Accident inv	restigation ould not be				M 1 🗆	Yes 2□i					
Ω	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	4 ☐ Homicide de	termined	building	, etc. (Speci	(b)	eet, factory, office			City or Town,	,		
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical	29a. Certifier 1 Cert (Check only one)	fying Phy ical Exam	ysician: To the be iner: On the basi and manner	s of examina	owledge, death ation and/or inv	occurred at the tirestigation, in my o	ne, date and pinion, deal	d place, and th occurred a	I due to the car at the time, da	use(s) and manne te and place, and	er as stat i due to ti	ed. ne cause(s)
	To the To the comp	X	29b. Signature and title of ce		a 1.			29c. Licens				d. Date signed (A		
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	0		30. Name and address of per		JP.			Print) TANCO) LUN	gneu	, MO	20912	2	
	Sta	_	31. Date filed (Month, Day, Y	ear)	32. Reg	istrar's Signa	ature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 30240 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** David Andrew Miller, Sr. 3_ 2007 4:50 P^M Sept. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chester River Hospital Chestertown Kent 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 579-36-7851 Director 79 May 10,1928 Maryland Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d Inside City Limits r 28a-f show notified at 10a. State 10b. County Caroline 1 X Yes 2 ☐ No MD Greensboro Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. o e 208 Christian Drive 21639 U.S.A. ral", or items 23a Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1√2 Yes 2 □ No 45-49 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🛣 No Specify: White Specify. \$ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 08 <u>Upholsterer</u> Furniture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Harvey Miller Isabelle Keithley ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau Sylvia G. Miller /spouse 208 Christian Drive; Greensboro, MD 21639 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham VetCem 9/10/07 Cheltenham, MD 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home, PA
PO Box 160; Greensboro, MD 21639

Anorroximate 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complication. That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to [or as a consequence of] Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ NO 24a. Was an has e 2 s autopsy certificate ha 2 No 1∐ Yes or Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner⁴ Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 1 | Yes 2 | No 2 ER/Outpatient 3 DOA 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 124 hours after death.

The Funeral Director Annetely filled in by the fi investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 2006 0301 29b. Signature and til e of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

122 Speer Road; Chestertown, MD 21620
Registrar's Signature

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

Peimer, MD

Ε.

SEP

Year)

6 2007

Michael 31. Date filed (Month, Day, 07-06715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Marvland / Department of Health and Mental Hygiene

2007 30241

itricia Calloway M		or State			Certific	ate of De	atn		Reg. N	lo.	
Physician/	-	pistrar Decedent's Name ((First, Middle,Last)					Mac	te of Death	v Year	3. Time of Death 1802 hrs
Examiner	l	Patrici	ia		.away		Morrow	Au	gust 29, 20	307 4c. County of De	
	48	Route 301 &	not institution, give s	street and number)			y, Town, or Locati per Marlboro	ion of Death		Prince Geor	
	5	Social Security Nur		7. Age	(In yrs. last bi	rthday) If l			Date of Birth(N	M/DD/YYYY) 9.	Birthplace (State or eign
Funeral Director	2	20-66-375	53 1 1	м 2 X F 5	0	Yrs.	onths Days H	ours Min. N	ov.9,1	1	Country) MD
era cortio additional	_	sual Residence of D	Decedent 0b. County		10c. City, Tow	n or Location					10d. Inside City L
≱	1		Anne Arun	de1	Sherw	ood For	est		63		1 Yes 2
he Maryland or 28a-f sh- iffed at once Director	1	0e. Street and Num				10f	Zip Code		10g.	Citizen of What C	
rith the Maryland 2.23a or 28a-f show a 2.notified at once. al Director		703 N Rol	bin Hood				21405	c Origin? (Specify	Vestor No-		nerican Indian, Black,
or items 23 must be no	1	Marital Status Never Married	d 2 X Married	12. Was Decedent Armed Forces?	·	If Yes, s	pecify Cuban, Mex	xican, Puerto Rica	n, etc.).	White, etc	
er deat		3 Widowed	4 Divorced		X No		2X No spe			Specify:	
urs aft tural" amine	2			or Dates: ly highest grade con	npleted) 16a	a. Decedent's U	sual Occupation (f working life. DO	Give kind of work on NOT use retired)	done 1	6b. Kind of Busine	ess/industry
5-0036 ed within 72 hour lygiene. to ther than "natu he Medical Exar		Elementary/Secon	ndary (0-12)	College (1-4 or 04	5+)		. N.		0.	Nursing	
within siene.		7. Father's Name (I	First Middle Last)		1		18.M	other's Name (Firs	st, Middle, Ma	iden Surname)	
21215-0036 Juidbe filed within 7 Mental Hygiene. marked other than it event, the Medica		John	Thou, made, and	Calla	away			Mary		<u>Hi11</u>	Note 7 Ondo
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Methal Hygien and Department of Heath and Methal Hygien dother than "tradural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	2	9a. Informant's Nar	me/Relationship (Ty her T. Mo	ype, Print)		19b. Mailing Ad 703 N R	obin Hoo	d Number or Rural	herwoo	d Forest	MD 21405
MD MD 2 sho m 27 is		20a. Method of Disp					(Name of cemete			20c. Location - Cit	
ore, es l ar of Hea If ite	1	1 Burial 2	X Cremation 3	Removal from S	tate cren	o Crema	olace)	9/1/0	7	Baltimor	e,MD
Baltimore, permit Pages I at Department of He Important: If ite	04	4 Donation 5	Other Specify: Ineral Service Licen	see ///				Facility		12 Ridg	elymbve140
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ysician	7	23a, Part I. Enter th	ne disease, or comp nly one cause on ea	lications that cause ach line.	d the death. Do	not enter the r	node of dying, suc	th as cardiac or res	spiratory arres	st, shock, or fleat	Between Ons Death
dical ⊏xaminer	١	Immediate Cause ((Final disease a.	Multiple Injurie							
		or condition resulting	h	Due to (or as a con	sequence or).						
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Box 6876 e death certificate the attending phy ed for use as the	Physician/M		No 9 V Unknow	4	at time of deat	n 5 Othe	(Specify)				
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rds, requir been s	Completed								24a. Was autop	sy pr	ior to completion of ca eath?
Recol The law cate has	duc								1 🗸 Yes		✓ Yes 2
Vital Reco ysician: The law this certificate has director, page 2 s	Be C	25. Was case refe		11			10	f Death (Check on ther:		Residence 6	Other: Scene
sicis se		examiner?	2 No	Hospital: 1 Inpa		R/Outpatient	3 DOA	at Work? 2	8d. Describe	now injury occurre	
this dir	2			20 a Data of	Inium/	28h Time of Ini	ırv 128c. Iniurv				
ding Phy After th	on: To	27. Manner of Dea	ath	28a. Date of (Month, Date Aug 29, 20		28b. Time of Inj 1719 hrs		s 2 V No S	ubject ster	oped into train	ic
Sion of V Attending Phy r death ector: After th by the funeral d		1 Natural 2 Accident	5 Pending Investiga	Aug 29, 20	av.Year) 007	1719 hrs		es 2 No Silding, etc. 2	8f. Location (Street and Numbe	iC er or Rural Route Num
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Sol.	Medical Certification:	Natural Accident Suicide Homicide 29a. Certifier 1 (Check only one) 29b. Signature ar 30. Name and ad Ana Rubic	5 Pending Investiga 6 Could no determine Certifying Physic Medical Examinand title of certifier Could not be seen to be s	Aug 29, 20 ation 28e. Place of the led (Specify) I ician: To the best of the ler. On the basis of and manner state the completed cause tant Medical Experience of the ler.	of death (Item	1719 hrs me, farm, street / Highway e, death occurre d/or investigation 23a) 111 Penn S	factory, office but ad at the time, date on, in my opinion, 29c. License O.C.M	e and place, and death occurred at number	e8f. Location (or Town, S oute 301 an	Street and Number state) d Swanson Rd. se(s) and manner and place, and di 29d. Date signer August 30,	or or Rural Route Num , Upper Marlboro, I as stated. ue to the cause(s) ad (Month, Day, Year)

07-06694 Catherine L. Nier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 30242

		Certificate of Death	Reg. No.
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year O045 bys
'Examiner	Catherine Lorraine Nier		Month Day Year 0815 hrs August 29, 2007
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	
	2509 Korvale Lane	Bowie	Prince George's
			8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral	5. Social Security Number 6. Sex 7. Age (In y	rrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	Foreign
Director	329-03-5371 1 M 2XF 90		Sept. 6, 1910 Country) IOWA
,	325 03 337.		
	Usual Residence of Decedent 10a, State 10b, County 10c.	City, Town or Location	10d. Inside City Limits
* any			1 X Yes 2 No
sho sho	MD Prince George's	Bowie	. 10g. Citizen of What Country?
Maryland 28a-f show d at once, rector	10e. Street and Number	10f. Zip Code	, Tog. Citizen of What Country?
death with the Maryland or items 23a or 28a-f sho must be notified at once.	2509 Korvale Lane	20715	USA
th the notion	11. Marital Status 12. Was Decedent Ever	in LLS 13 Was Decedent of Hispanic Origin? (S	pecify Yes or No- 14. Race - American Indian, Black,
t be	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.) White, etc.
r death with or items 23 must be no Funeral	1 Yes 2 A	No 1 Yes 2 X No specify:	Specify: White
윤 달림 >	3 X Widowed 4 Divorced If Yes, Give Year or Dates:		
5-0036 ed within 72 hours a other than "natura the Medical Examin Completed by	15. Decedent's Education (Specify only highest grade complete	during most of working life. DO NOT use re	tired)
36 hin 72 hours than "nate stical Exam	Elementary/Secondary (0-12) College (1-4 or 5+)		D 1-14 - 111-114 - Co
np edic than	12	Telephone Operator	Public Utility Co.
5-0036 led within 72 hours Hygiene other then "nata the Medical Exan Completed	17. Father's Name (First, Middle, Last)	18.Mother's Nam	ne (First, Middle, Maiden Surname)
215 be file ntal H- rked o ent, tl	William Rooney	Carrie	Daniels
2121 ould be fil ould be fil I Mental H s marked ic event, To Be	19a. Informant's Name/Relationship (Type, Print)	. 19b. Mailing Address (Street and Number or	Rural Route Number, City or Town, State, Zip Code)
AD 21215-0036 2 shouldbe filed within 72 hours h and Mantal Hygiene. 27 is marked other than "natur maric event, the Medical Exam To Be Completed	Michael C. Rooney / nephew	2509 Korvale Lane	Bowie, MD. 20715
e, MD I and 2 sho Health and Item 27 is	20a. Method of Disposition	20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
Baltimore, N permit. Pages I and Department of Health Important: If Item Injury or other tran	4 During 2 X Cromation 3 Removal from State	crematory or other place)	3
nt or oth	4 Donation 5 Other Specify:	Metropolitan Crematory 08	3/31/2007 Alexandria, VA.
Baltime	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	Beall Funeral Home
Balti permit. Departu Import injury	PR. Vandl	6512 NW Crain Hwy	y. Bowie, Maryland 20715
ALTERNATION NO. 184	23a. Part I. Enter the disease, or complications that caused the	death. Do not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart Approximate Interval
hysician	failure List only one cause on each line.		Between Onset and Death
/ledical	minociate accident	rosclerotic Cardiovascular Disease	
_xammer	or condition resulting in death) Due to (or as a consequence)	ence of):	
	Sequentially list conditions, b		
Jer	if any, leading to immediate Due to (or as a conseque	ence of):	
i i	cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence)	once of):	
red nsit Examine	events resulting in death) Last Due to (or as a consequent	since ory.	
760, Trate be executed sphysician and the burial - transit	d		
0, e be execut ysician and burial - tra	UNPENDED AMENDED		
760, icate be g physicathe burnthe bur	IF FEMALE: 23c. If yes, outcome of		23d. Date of delivery Month Day Year
ng p as th	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pres	nancy Month Day Year
he death certiff the death certiff the death certiff the attending ched for use as Physician	past 12 months?	e of death 5 Other (Specify)	
deat deat	1 Yes 2 No 9 V Unknown 9 Unknown		23e. Did tobacco use contribute to the cause of death?
Records, P.O. Box 68: The law requires that the death certificate has been signed by the attending page 2 should be detached for use as completed by Physician	Part II. Other significant conditions contributing to death be	it not resulting in the underlying cause given in Part I.	
P.O. es that the signed by be detac			1 Yes 2 No 3 Probably 4 V Unknown
Records, The law requires freate has been sig page 2 should be Completed			24a. Was an 24b. Were autopsy findings available
s bec			autopsy prior to completion of cause of death?
e lav			1 ✓ Yes 2 No 1 ✓ Yes 2 No
		26.Place of Death (Che	ck only one)
Vital Reciysician: The lathlitic certificate his certificate his director, page 2		2 ER/Outpatient 3 DOA Other Nu	rsing Home 5 Residence 6 Other: Scene
Physic r this al dir	1 ✓ Yes 2 No	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
J of V	27. Manner of Death 28a. Date of Injury (Month, Day, Year		
endi ath.	1 V Natural 5 Pending 2 Accident Investigation		
isior Attend or death. rector: by the	2 Accident Investigation 28e. Place of Injur	y - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director, After this certificate has been s completely filled in by the funeral director, page 2 should the	3 Suicide 6 Could not be determined (Specify)		or rown, ototo,
	29a Certifier	nowledge, death occurred at the time, date and place,	and due to the cause(s) and manner as stated.
D To the Hospital within 24 hours To the Funeral completely fille	(Check only 1 Certifying Physician: 10 the best of my k	nation and/or investigation, in my opinion, death occurred	ed at the time, date and place, and due to the cause(s)
To the Ho within 24 To the Fu completely	one) 2 Medical Examiner: On the basis of examination and manner stated.		29d. Date signed (Month, Day, Year)
T S F S	29b. Signature and title of certifier	29c. License number	
	1 Queta	O.C.M.E.	August 30, 2007
0 61	30. Name and address of person who completed cause of dea	ath (Item 23a)	
			201
11-13/	Ana Rubio MD Assistant Medical Examin	ner 111 Penn Street, Baltimore, MD 21.	
1-(3)	Ana Rubio MD. Assistant Medical Examine 31. Date filed (Month, Day, Year) 32. Registrar's	ner 111 Penn Street, Baltimore, MD 21.	

State of Maryland / Department of Health and Mental Hygiene 0 0 7 30243 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2, 2007 **Physician** Leon Stephen Odachowski 5:46a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Dec. 26, 1 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☑ M 2 🗆 F 214-26-2075 Yrs. 78 1928 Maryland Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or iteme 23a or 28a-f show the Medical Examinations! be notified at MD Anne Arundel 1 ☐ Yes 2√2 No Director Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1139 Latrobe Drive 21409 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: Completed by Korean 3 12 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Printer Federal Government 11 it of Health and Mental Hyg If item 27 is marked other or other treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Odachowski Stephanie Sobotka ပ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie Ann Lester/Daughter 957 Dogwood Tree Drive Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Cedar Hill Cemetery Brooklyn, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Barranco & Sons, P.A.
495 Gov. Ritchie Hwy. Severna Park Funeral H Severna Park, MD 21146 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STAPHYLOCOUN SEPSIL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Completed by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OUCESTIVE HYNZE FAILURG 1 Yes 2 No 3 Probably 4 Onknown peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy rmed? 20 No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Dippatient 2 ER/Outpatient 3 DOA Certification; To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending 1 Natural Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide filled within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical The Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 739637 9-2-7 DS MITCHELL MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway DS MITCHELL Annapolis, MD 21401 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar SEP 0 4 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30244 Reg. N2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September **Physician** 2007 10:05 a M /Medical Barry Perry 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Hospital Lanham Prince George's 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Hours 1 M 2 □ F Director 48 216-78-8885 1959 | Cambridge,MD Jan 26 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County Prince George's MD 1 Tyes 2 □ No Director Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10514 Vista Gardens Drive 20720 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Black 1 ☐ Yes 2 ☒ No Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Draftsman Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Barbara Giles Theodore P. Perry 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gardens Drive Bowie, Maryland 20720 Barbara Perry/Mother 10514 Vista 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 N Burial 2 □ Cremation 3 □ Removal from State Harmony Cemetery 9/8/2007 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurg. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia **Physician** disease or condition resulting in death) 2 days Due to (or as a consequence of): Caroliumy pathy Due to (or as a cons quince of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disease Dixlysis Dependent Renal Exami Stage Due to (or as a consequence of) Physician/Medical Malignant IF FEMALE: // A
23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No N/A 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 2 Accident

/Medical Examiner certificate be executed burial-transit and Division or Vital Records, P.O. Box 68760 attending physician the as use jo the detached signed by d page 2 s has certificate this

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

Is marked other than

Injury or other traumatic

2 should be finance and Mental H

permit. Pages 1 and 2
Department of Health au
Important: If item 27 is,
any injury or other terms

Maryland 21215-0036

Baltimore,

Certification:

3 Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certified

To the Hospital or Attending within 24 hours after usum.

To the Funeral Director: Af cal Medi

State Registrar 5 Pending investigation 6 Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number 1)41182

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

FT. WAShinghy, MD 20744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anderson 31. Date filed (Month, Day, Year) SEP 0 6 2007

MO 9400 Livingston 32. Registrar's Sign ture

and manner stated.

1. Decedent's Name (First, Middle, Last)

2. Date of Death

Month

3. Time of Death

Year

Division or Vital Records, P.O. Box 68760 attending physician for use as the buria funeral director,

Carlton Harvey Porter 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Caroline Caroline Home for Hospice Denton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1**X**M 2□ F 86 Director 3 1921 Maryland 220-01-8913 Aug Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show be notified at 1 ☐ Yes 2 No Caroline Maryland Greensboro Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 21639 14152 Cedar Lane U.S.A. "natural", or items 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married ^{2□No} 45-58 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) dairy farm inspector dairy industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Harvey Porter Margaretha Kornumpf ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen B. Porter/ wife 14152 Cedar Lane; Greensboro, MD 21639 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Greensboro Cemetery 9/6/07 Greensboro, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode or dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final wosepsus Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Spice 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural Injury To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signato 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BURT 32 Registrar's Signature 31. Date filed (Month, Day, Year! State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 30246 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** RAYMOND LEE PARSONS 0950 AM August 2007 27 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Merronal Hospital

5. Social Security Number 6. Sex Easton Under 1 Year | If Under 24 Hrs. Easton Talbot 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 🖾 M 2 🗆 F 70 Feb.2,1937 Maryland 220-32-2409 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 X Yes 2 □ No Federalsburg Director MD Caroline 10g. Citizen of What Country? 10e. Street and Number 202 Pebble Street 21632 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 21∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 X Married 'natural", or 1 ☐ Yes 2 ☐XNo Specify: White Specify: \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Acme Market permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 Is marked other this any injury or other traumatic event, the Jenes. Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James M. Parsons Edna Smack 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla Parsons/Wife 202 Pebble Street, Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition IX_INBuria! 2 ☐ Cremation 3 □Removal from State Hill Crest Cem. 8/30/07 Federalsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility 7. Eskort Framptom Funeral Home, Federalsburg, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ATHEROSCIEROTIC CARDIOVASCULAR DISEASE Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): RIGHT IMPACTED HUMERUS NECK FRACTURE 20 to OSTEUPORUSIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Dav Year 5 ☐ Other (specify) 4□Pregnant at time of death 1☐Yes 2☐No 9□Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 Mo 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) отпретелу and manner stated

State Registrar

JOHN 31. Date filed (Month, Day, Year)

AUG 2 8 2007

29b. Signature and title of certifier

219 S. WASHINGTON ST, 2. Registrar's Signature

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOTS14

DHMH 17 Rev 1/2001

29c. License number

200 59487

29d. Date signed (Month, Day, Year)

21215-0036

Maryland

Baltimore,

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day September 6, 2007 1:40 NAOMI Η PETRIE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 ☐ M 2 ☐ F 577-16-9718 93 Sept 16, 1913 Pennsylvania 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7400 Willow Road, Apt. 324 21702 USA

Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker 12 own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Charles Manning Hunter Olive Emmerich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kenneth G. Petrie, son 125 Greenwood Creek Road, Queenstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Damascus Cemetery 9/11/2007 Damascus, Maryland 22. Name and Address of Facilit Molesworth-Williams, PA, Funeral 21. Signature of Dineral Service Licen-Home, 26421 Ridge Road, Damascus, MD 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition)

INTRACEREBRAL HEMORRHA Approximate Interval Between Onset and Death HEMORRHAGE HOURS resulting in death) Due to (or as a consequence of) Due to [or as a consequence of]

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

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Director

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

and page 2 After Director:

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Examine Physician/Medical þ Be Completed Certification: To

Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

hours after 24 hours a

within 24

State Registrar

MA

20061410

29d. Date signed (Month, Day, Year)

14. Race - American Indian.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GAFFAR SYED A.

TOLL HOUSE AVE. 801 H4. FREDERICK, MD

31. Date filed (Month, Year) istrar's Signature 2007

			State Amend #8,19b, 9-6-	of Maryland / De 07, per FHDR	partment of H	ealth and M D <i>eath</i>	lental Hyg R	eg. No 200	7 30248
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).	Examin		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or	Location of Death		4c. County of D	
			Shady Grove Adventist	Hospital	Rockvill lav) If Under 1 Year	e If Under 24 Hrs.	8. Date of Birth	Montgom	ery Birthplace (State or Foreign
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и	Director		Usual Residence of Decedent	30			Nov. 5	, 19 48	
	land ow		10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
	Mary -f sh	ţŏ	MD Montgomery	Gaithers	burg				1 □Yes 2 🛣No
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Š	alth a alth a 27 is		Trent Paul/brother	110	Ames Rd.	# 110 D S	ilver Sp	ring, MD	20903
ē,	of He		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal f	cemetery	isposition (Name of crematory or other place	ce) ¦	Date	20c. Location - City	
Ē	Page nent ant: If		4 □ Donation 5 □ Other (Specify)	Chesape	eake Cremat	- :		Beltsvill	-
Baitimore, Maryland 2	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		21. Signature of Funeral Service Licensee Beverly L. Reck	rotte MO1251	Going Home Beverly L.	ss of Facility Cremation Heckrott	on Servi	ce P.O. Clarksvi	Box 784 11e, MD 21029
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è	/Medical		resulting in death)	e to (or as a consequence of)	:				
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<u> </u>		Completed			·		1□ Yes	2 No 1 □	Yes 2 □ No
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2	after after Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify)			City or Tov	vii, State)	
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	To the within 2 To the complex	Me	29b. Signature and title of certifier		29c, Licens	se number		29d. Date signed (i	Month, Day, Year)
			MD		Do	064560		Sept 4,	2007
6	12		30. Name and address of person who completed	cause of death (Item 23a) (T	ype, Print)	0 01	10 - 1	. 0	1. 1/2 112
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	St Regist	ate trar	31. Date filed (Month, Day, Year) SFP 0 6 2007	32. Registrar's Signature	Soule				Month, Day, Year) 2007 LVIIIL, MI

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32. Registrar's Signatur

		1 - State of Maryland / De State of Maryland / C	partment of Hea ertificate of De	alth and Mer	ntal Hygie	ne No.2007		
Physic		Decedent's Name (First, Middle, Last) GLENDA RIOS			Date of Death Month ugust 30	Day 200 ^{Year}	3. Time of Death 4:30 pM	
/Med Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death			4c. County of Death PRINCE GEORGE'S			
Funeral		PRINCE GEORGES HOSPITAL 5. Social Security Number 6. Sex 1	Months Days Ho	Under 24 Hrs. 8.	Date of Birth (Month, Day, Ye	9 Rint	hplace (State or Foreign	
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h the N r 28a-f	irect	MD PRINCE GEORGE S 10e. Street and Number	RIVERDA 10f. Zip Code	LE	10g	. Citizen of What Co		
s 23a c	Funeral Director	6902 VALLERY STREET		.0737		Salvador		
urs after de al', or item Examiner p	Ş	11. Marital Status 1 ☑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes, 2 ☑No If Yes, Give Year or Dates:	3. Was Decedent of Hispar If Yes, specify Cuban, M 1 ☑ Yes 2 ☐ No Sp		adorian	14. Race - Amer Black, White Specify: His	e, etc.	
I E, INIAI yIAIIU ZIZIDJOO S 1 and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during b. DO NOT use retired) metology	n ng most of working		b. Kind of Business/leauty Salo		
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t and 2 sho t and 2 sho Health and I tem 27 Is ma other traume	10000	19a. Informant's Name/Relationship (Type. Print) VICENTE RIOS (father) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6902 Vallery Street Riverdale, MD 20737					(ip Code)	
Datumore, permit. Pages 1 an Department of Heal important: If Item 2 any injury or other once.		1⊠ Burial 2 □Cremation 3 □Removal from State Parque	sposition (Name of the matery protection) Melinorial sides and solid sides and solid sides are solid sides and solid sides are solid sides and solid sides are	09/11	Sa	c. Location - City or an Miguel, El Salvado	, La Union	
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Physician /Medical	ı	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):						
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To the Hospital or Attending Physician: The law requires that the death certification after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed	24a. Was an autopsy preformed?				prior to death?	topsy findings available completion of cause of	
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of or Atter	Certification:	3 Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f.	Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,	
re Hospita 124 hours ne Funera	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
To th withir To th	Me	29b. Signature and title of certifier	29c. License nur	_		Date signed (Monti	Day, Year)	
2		30. Name and address of person who completed cause of death (Item 23a) (Type 200 and 2	e, Print) Dr Ch	60,00	1. 0- 1	7/4/0	05	
St	ate	31. Date filed (Month, Day, Year) 32. Hegistrans Signature	Tal DY CI	KVET/	4 1112	0018	3	
Regist	rar	SEP 0 6 2007 Sacret B. Speck						

07-06779

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 30251 Vanessa Riddick Certificate of Death 1- For State Rea. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 31, 2007 1745 hrs Medical Examiner Vanessa Gail Riddick 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Upper Marlboro 10222 Prince Place #101 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (in yrs. last birthday) 5. Social Security Number **Funeral** Country) Months Days Hours Director 579-74-4261 M 2X F 954 53 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10h County 1 X Yes 2 No Upper Marlboro Prince George's 28a-f show Maryland with the Maryland Director 10g, Citizen of What Country? 10f, Zip Code 10e. Street and Number 23a or 28a-f notified at s United States 20774 10222 Prince Place #101 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.). 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11 Marital Status White, etc. or items Armed Forces? Married 1 Never Married 2 hours after death 2 X No Yes If Yes, Give Year 1 Yes 2 X No specify: Specify: Black 4 X Divorced 3 Widowed <u>م</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed ii. Pages 1 and 2 should be filed within 72 hou timent of Health and Mental Hygiene tariff. If them 27 is Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Cleaning Company event, the Medical 12 years 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Christine Davis Robertson Be Herman Carraway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print.) ٥ 14100 Bramble Court #203 Laurel, MD 20708 Vanecia Holmes - Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition · Itimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Sept. 8, 2007 Suitland, MD Cedar Hill Cemetery epartment c Important: injury or oth Donation 5 Other Specify 22. Name and Address of Facility Stewart Funeral Home, Inc. ermit. 21. Signature of Funeral Service Licenses 4001 Benning Road, NE Washington, DC 20019 23 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-Approximate Interval Between Onset and Physician failure. List only one cause on each line Death 1edica Multiple stab and cutting wounds Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi Physician/Medical AMENDED physician the burial -UNPENDED The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth use as t past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown for 9 Unknown ned by the a detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ó signed be be deta 1 Yes 2 ✓ No 3 Probably 4 Unknown Þ م Completed 24b. Were autopsy findings available of Vital Records, 24a. Was an his certificate has been director, page 2 should prior to completion of cause of autopsy death? performed' 1 🗸 Yes 2 Nο ✓ Yes 2 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be Other₄ Residence 6 🗸 Other: Scene Hospital: 1 examiner? Nursing Home 5 DOA ER/Outpatient 3 Inpatient this ٩ 1 V Yes 28d, Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 27. Manner of Death Subject stabbed and cut FOUND: Yes 2 V No Natural Division Pending the 1741 hrs within 24 hours after death To the Funeral Director: Aug 31, 2007 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc filled in by or Town, State) 10222 prnce Place #101, Upper Marlboro, Md. 3 Could not be Suicide determined (Specify) Single Family 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier September 1, 2007 mi O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 0 6 2007 State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

ORIGINAL

Registrar

State of Maryland / Department of Health and Mental Hygieney 30253 1- State Amend #18, 9-6-07, per FHDR, HSHP ifficate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r^{Day}2, 2007 **Physician** September 12:36 A M Joanna Reese /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Geheral Hospital Montgomery 01nev 8. Date of Birth (Month, Day, Year)
May 30, 1930 5. Social Securify Number 6. Sex 7. Age (In yrs. last birthday, if Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 9. Birthplace (State or Foreign **Funeral** Country PA 1 □ M 2 🗓 F 159-26-5130 77 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10h County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Sandy Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20860 USA 17300 Quaker Lane #D24 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 27 No Specify Specify: White <u>م</u> 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) is marked other than Elementary/Secondary (0-12) Non-Profit Activist injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental George Ashcroft Lyons Joanna Reese Joanne Reese-19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health a:
Important: if item 27 is
any injury or other trau 1716 Cheyenne St., Sarasota, FL 34231 Joanne Waterbird, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 9/5/07 Beltsville, MD 22. Name and Address of Facility
Going Home Cremation Service PO Box 784 21. Signature of Funeral Service Licensee /aJ M01251 elpure Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Multiple Okgaw

Due to (or as I consequence of): disease or condition resulting in death) /Medical Examiner Due to as a consequence of Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) Division or Vital Records, P.O. 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate sompletely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA P 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending Fafter death. After Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital within 24 hours a 29a. Certifier 1 Cruifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 2,2007 024190 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3416 Olandword Ct #205 Olkey, Manyland 20832 Woodenavel ARTHUR JR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State doline Registrar SEP 0 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30254 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 28,2007 **Physician** 6:50 P M Robinson William Earl /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** 5/9/1941 Year) Days Hours Min 1 ∏ M 2 □ F Calvert Co. MD 214-48-9524 66 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Forestville MD Prince Georges Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20747 USA 2728 Lorring Drive Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 Zano If Yes, Give Year or Dates: r than "natural", or items. 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 🛣 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life., DO NOT use retired)

Bridge Crew I Hygiene. College (1-4or 5+) P.G. County Gov'T Elementary/Soosndary (0-12) marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be flik Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Alice Ramsey Robinson Tsaac 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2728 Lorring Drive Forestville,MD 20747 Pamela Robinson Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 9/1/07 Baltimore, MD Metro Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Fameral ervice Licenses 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Ave Ann, MD Day Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ONOMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Por 4□Pregnant at time of death 5 Other (specify) □Yes 2 □ No the detached 9□Unknown 9 Unknown signed by 23e. Did tohacco use contribute to the cause of death? ath but not resulting in the underlying cause given in Part I. ò be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has nerform certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 212 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28h. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

Division or Vital Records, P.O. al or Attending Patter death. completely filled in by the the Hospital within 24 hours a To the Funeral (

certificate be executed

Box 68760

death with the Maryland

within 72 hours after

Maryland 21215-0036

Baltimore,

Medical State 29a. Certifier

29b. Signature

Registrar

0 4.2007

Day. Year)

to the cause (s) and manner as stated.

29c. License number

niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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29d. Date signed (Month, Day, Year)

Yazdani

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPT.15, Day 2007 **Physician** 2:38 A BLANCHE HOUSTON SMITH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5505 CONSENT DRIVE PORT REPUBLIC CALVERT If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year 7 – 6 – 1 9 2 5 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 X 231-24-7012 82 VA. Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes X2 ☐ No Funeral Director MD. CHARLES BRYANS ROAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be 7312 CARROLL DRIVE 20616 U.S.A. death ral", or items 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: WHITE 3 X Widowed 4 ☐ Divorced "natural" event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SYSTEMS ANALYST U.S.GOVT 12th Pages 1 and 2 should be filed in nent of Health and Mental Hyginnt: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HOMER LINKOUS CORABELLE PRICE ပ other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENISE SHELTON-DAUGHTER 5780 LOLETTA LN. MARBURY, MD. 20658 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H important: If ite any injury or of once, 10-2-07 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON NATIONAL CEM. 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON, VA. 21. Signature of Ineral Service Licenses M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD 20646 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner g physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown UMOUR 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 XNo or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury Natural 5 ☐ Pending To the Funeral Director, Aff 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 20 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 30256 State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** SHARLOW 08:05AM eptember 03 6007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner JOHNS HOPKINS BALTIMORE HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs./ 8. Date of Birth (Month, Day, Year) Feb. 14,1940 Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours 1 XM 2 F Yrs. 134-30-2469 67 New York Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. Count 10c. City, Town or Location r than "natural", or Items 23a or 28a-1 show the Madical Exactinet must be notified at 1X Yes 2 No Director Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2712 Felter Lane 20715 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1958-61 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ğ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. other than personnel Manager U.S. Govt. 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked othen eny injury or other treumatic event once. 17. Father's Name (First, Middle, Last) Be Carson Sharlow Erma Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary M. Sharlow / spouse 2712 Felter Lane Bowie, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 09/07/2007 Alexandria, VA. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie, MD. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Abnormal Physician /Medical Due to (or as a consequence of): Examiner S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-transit Mι CUTC Due to (or as a consequence of Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 DEctopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 22 No 1 Yes Division of Vital the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of eath 28d. Describe how injury occurred 28b. Time of Certification: After 1 Natural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number > Michelle Zikustra, MEDICAL DOCTOR RES-000 September 03,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 6 2007

MICHELLE ZIKWOKA, JOHNS HOPKINS HOSPITAL, 600 NOITH WOLFE STREET, BALTIMORE, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007

			1 - State Registrar	State of Ivia	•	ertificate of			eg. No.	0020.
			1. Decedent's Name (First, Middle, La	st)				2. Date of Deat Month	h Day Yeer	3. Time of Death
Tuz.	Physicia /Medic		George	Schaefer,	Ir.			Septemb		2:03 P M
1	Examin		4a. Fecility Name (If not institution, giv	street and number)		4b. City, Town, o	or Location of Death		4c. County of Dee	th
			Caroline Nursing			Denton			Carolin	
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthd	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		thplece (State or Foreign ountry)
	Director	9	146-26-5106	Ç 2	87 Yrs	•		December	4, 1925 New	Jersey
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town o	r Location				10d. Inside City Limits
	f sho	0	Maryland Caroli	n a	Dentor					1 ☐ Yes 2 € No
	the 28a	Director	10e. Street and Number	ite	Dercoi	10f. Zip Code		1	0g. Citizen of What Co	ountry?
	3a or		26144 Sennett Roa	d		21629		11	nited Stat	es of America
	death ms 2	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.	3. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp		14. Race - Ame Black, Whit	erican Indian,
ထ	after or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give	lo .	1 Tes, specify Cub		Hican, etc.)	Specify:	18, 810.
S	filed within 72 hours after death with the Maryland Hygiene. the than natural; or Items 23e or 28e-f show ont, the Magical Examiner rust be notified a	Completed by	3 Widowed 4 □ Divorced	Year or Dates:		10163 2210	ареспу.		Ca	ucasian
5 - -	72 h	etec	15. Decedent's El (Specify only highest gra	ducation ide completed)	1 (6	cedent's Usual Occup ive kind of work done	during most of work		16b. Kind of Business	/Industry
21	Athin De.	ld I	Elementary/Secondary (0-12)	College (1-4or 5	+)	e. DO NOT use retire			T : / T	
7	filed with Hygiene. ther the		12 HS grad 17. Father's Name (First, Middle, Last,	1	<i>fw</i>	rmer/Truck	18. Mother's Nam	e (First Middle I	Farming/F Maiden Sumame)	uer ou
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ž	should to	To	19a. Informant's Name/Relationship (19h M	ailing Address (Street	1-		, City or Town, State,	Zip Code)
Maryland 21215-0036	01 10 - 6		David Schaefer	Son					aryland 21	
တ်	1 and 2 Health tem 27 other tra		20a. Method of Disposition			sposition (Name of crematory or other pla			20c. Location - City or	
<u>o</u> u	Pages nent of int: If it		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specif	Removal from State		r Cemetery		/2007	Denton, Ma	nuland
Baltimore,	permit. Pages 1 ar Department of Hea Important: if item eny injury or othe once.		21. Signature of Funeral Service Lices	2909		22. Name and Addre	ess of Facility	рΔ		otyculu
0	82528	110	23a. Part1. Enter the disease, or comshock, or heart failure. List only	111000		12 South	Second St	reet. De	nton, Mary	Pand 21629
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g.	Physician		disease or condition	. Pue	MMO	VIa				IWEEK
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of)					
5	148	-	Sequentially list conditions,	b. Due to (or as	a consequence of)					
	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause Enter Uncertying Cause (Disease or injury	500 (0) (0)	2 0011004251100 517					
	tificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of).					
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89	ificate g phy as the	edical								
Вох	leath certifi attending I for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		2 December programs			23d. Date of de	
	The law requires that the death cer ate has been signed by the attendin age 2 should be detached for use	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at	2 ☐ Fetal death time of death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _			Month	Day Year
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	res tha igned be del		Part II. Other significant conditions	//	ut not resulting in th	e underlying cause gr	ven in Part I.		bacco use contribute t	
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င္ပ	as be	Completed by	cerebrova	iscula	rac	ciden	16	24a. Was a autops	sy prior to	utopsy findings available completion of cause of
H		Con						perform 1 ☐ Yes		s 2 No
Vital Records,	ysician: The is certificate director, pag	Be (25. Was case referred to medical examiner?	11				th (Check only on	Ie)	
	Physi this c	Jo	1 ☐ Yes 2 ☐ Mo	Hospital: 1 Inpatie		Itient 3 DOA			ence 6 Other (Spe	ecify)
no On	Attending Physician: r death. ector: After this certific by the funeral director.	lon	27. Mannar of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry Yeer) 28b. Tim Inju	ry Wo	ork?]Yes 2 □No	200. Describe no	ow injury occurred	
isio	death death stor:	Icat	2 Accident investigation 3 Suicide 6 Could not be	e 29a Place of Ini	ury - At home farm	, street, factory, office]163 2 110	28f. Location (Si	treet and Number or F	Rural Route Number.
Division of	in Sire	Certification;	4 Homicide determined	building, et		, street, ractory, office		City or Town		
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After com, letely filled in by the funer	edical C	(Check only 2 Medical Exe	miner: On the basis of	examination and/				ause(s) and manner a late and place, and du	
	the the model	Med	one) 29b. Signature and title of certifier	and manner sta	ated.	29c. Licen	se number	2	29d. Date signed (Mon	nth, Day, Year)
)	Mill To		A	21. 8	.6/2	/ D=	31370	6	9/1/2	7
			30. Name and address of person who	completed cause of d	eath (Item 23a) (Tu	pe, Print)	110		110101	
			JAMES S	iles	MD	920 M.	inket	50	De IIIn.	NMQ
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature					,
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 07

1- State Amend #5, 10e, 10f, 16a, 16b, Certificate of Death
Registral 9a, 19b, 20a, 22, 9-6-07, per FHDR, HCHD, al 2 Date of Death
1. Decedent's Name (First, Middle, Last) 30258 3. Time of Death **Physician** Brendo 200 13:45 pm 02 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner land University of Mary 1 5. Social Security Number Baltimore Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 231-56-5088 1 ☐ M 2 🛱 F Director 64 Nov 24, 1942 Virginia Usual Residence of Decedent Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f ehow must be notified at 1 ☐ Yes 2 ☑ No Director MD Prince George's Beltsville the 10e. Street and Number 4501 Romlon Street #T-4 10f. Zip Code 10g. Citizen of What Country? With ö -9001 Cherry Lane 20708 USA or items 23a 20705 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status of filed within 72 hours after de l'Hygiene.

Other then "naturel", or item the Medical Exerciner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Advertising College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: if item 27 is marked other than eny injury or other traumatic event, Italy one. Sales marketing 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Ross Prater Opal Adkins 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unkChristopher Saba / sense 4501 Romlon Street #T-4 Beltsville, MD 20705 20a. Methodistopher Saba / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 □ Donation 5 ₩ Other (Specify) Chesapeake Crematory 9/6/07 Beltsville, MD 22. Name and Address of Facility Going Home Cremation Service 21. Signature of Funeral Septice Licensee Ronald S. Wad Director Is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate 23 Part Enter the dise se, or 5 hr fic 14 s hat caused it shock or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cluse (Final disease or condition resulting in death) **Physician** Cholestatic /Medical Examiner Clebsiella pact Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 0 detached 9 Unknown څ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 2 No Division of Vital NE Yes the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Daje signed (Month, Dey, Year) ္ရ The 30. Name and address of person who cause of death (Item 23a) (Type, Ca BAHO, MD 21201 225 GIEENT SK 101 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State SEP 0 6 2007 Registrar

/Medical Examiner **Funeral** Director 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 Is marked other than "natural", or items 23a or 28a-4 show a or 28a-f sh Director items 23a o iner must be Funeral "natural", or iten Baltimore, Maryland 21215-0036 þ Completed Be 27 Is marked traumatic permit. Pages 1 and Department of Health Important: If Item 27 any injury or other to once.

> Physician /Medical Examiner

physician and s the burial-trans been signed by the should be detached certificate funeral After ours after death.

neral Director: Af
filled in by the fur

Division or Vital Records, P.O. Box 68760,

30259 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Erin Kae Sornberger P_M 2007 3:05 August 28 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1901 West Street, Apt. Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months 1 □ M 2 X F 576-33-3515 35 April 6, 1972 Germany Usual Residence of Decedent 10c, City, Town or Location 10b. County 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1901 West Street, Apt. 435 21401 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 25 Married White 1 ☐ Yes ŽŽNo Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Government College (1-4or 5+) Elementary/Secondary (0-12) Congressional Analyst Contracting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John T. Sornberger Mary Jane Quinn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Joshua Stewart/husband 1901 West Street, Apt. 435 Annapolis, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/2/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 00 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Cardiac Arrhythmia Due to (or as a consequence of): Cardiomegaly Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) 9 🔀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform XXNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1**X7**¥Yes 2 ∏ No ို 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1XX atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**EXMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) eputy 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed care se of death (Item 23a) (Type, Print) William P. Jones, 695 America MDDavidsonville, Maryland 21035 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar SEP 0 5 2007

within 24 hours a

To the Funeral I

completely filled

07-06825 James Stockett Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hydiene

Physician/	Registrar					No.	
	Decedent's Name (First, Middle,Last)				2. Date of Death Month)ay Year	3. Time of Death 1945 hrs
edical Examiner	James 2. Seconos, III		1 h City Town 6	or Location of Death	September	2, 2007 4c. County of Death	
	(4a. Facility Name (if not institution, give street and number) Anne Arundel Med. Ctr.		Annapolis,			Anne Arundel	
Funeral	5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Ye		. 8. Date of Birth	(MM/DD/YYYY) 9. Bir Foreig	thplace (State or
Director	212-13-0115 1XM 2 F 25	, Y	rs. Months Da	ys Hours Min.	02/08/	/1982 co	untry) Maryland
	Usual Residence of Decedent 10a. State 10b. County 1	IOc. City, Town or Loc	cation				10d. Inside City Limits
<u> </u>	Maryland Anne Arundel	Edgewa	ter				1 Yes 2 X No
the Maryland to 28a-f show ifred at once.	10e. Street and Number		10f. Zip Code		100	Citizen of What Cou	ntry?
th the last or notifie	· L	I42.1	2103	/ Hispanic Origin? (Sp	pecify Vesion No-	USA	ican Indian, Black,
ath wil	11. Marital Status 12. Was Decedent E Armed Forces?	X No	of Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	White, etc.	
fter de I'', or ner mu	2 Widowed 4 Divorced If Yes, Give Year	1	Yes 2 y N			ap cony.	White
inatural" xamine	15. Decedent's Education (Specify only highest grade comp	during	dent's Usual Occup most of working li	eation (Give kind of v fe. DO NOT use reti	vork done red)	South Riv	
5-0036 led within 72 hours at Hygiene. other than "natural to Medical Examin	Elementary/Secondary (0-12) College (1-4 or 5-12 th		Supervi	sor		Restorati	
-0036 d within 7 ygiene. when than be Medical	1 1711 action of the time (18.Mother's Name			
215 be file ntal H rked ent.	James B. Stockett, Jr				ta Kay M	iller ber, City or Town, Stat	7in Codo)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heakh and Mental Hygeine. Important: If litem 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) James B. Stockett, Jr./ Fa					, MD 21037	
e, M 1 and 2 Heakh item 2	20a. Method of Disposition		position (Name of or other place)	cemetery,	Date	20c. Location - City o	r Town, State
nor Pages ent of nt: If	1 Burial 2 X Cremation 3 Removal from Sta 4 Donation 5 Other Specify:	"Kalas Cr	ematory		and the state of t	Edgewater	
salti	21. Signatur Fra I Service Licensee	2				Kalas Fune	
	23a. Part I. Enter the disease, or complications that caused	the death. Do not ente		ng, such as cardiac o	or respiratory arre	Edgewater, st, shock, or heart	Approximate Interval
Physician /Medical	failure. List only one cause on each line.			್ ಪ್ರೀ ಕಾಣ್		z z	Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death) a. MUITIPE TITUTES Due to (or as a conse	quence of):					
l-g	Sequentially list conditions, if any leading to immediate Due to (or as a conse	guence of):					
ed nsit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				7		
ted ansit	events resulting in death) Last Due to (or as a conse	equence of):					
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit properties of the Development of Personal Action 1997	UNPENDED X AMENDED X DETME, 9	872, 10/3/07	' गुग				
68760, sertificate be oding physic se as the buritary	IF FEMALE: 23b. Was decedent pregnant in the	ne of pregnancy		3 Ectopic pregn	ancy	23d. Date of delive Month	ry Day Year
Box 6876 he death certificate the attending phy hed for use as the boxes.	nast 12 months?	time of death 5	Fetal death Other (Specify)	SEstopio progn			
Box e death c the attented for us				e siven in Bort I	23e Did to	bacco use contribute t	o the cause of death?
P.O.	Part II. Other significant conditions contributing to death	n but not resulting in t	ne underlying caus	se given in Part i.		2 ✓ No 3 Pr	
cords, P.O. law requires that has been signed to should be detailed by the standard by the sta					24a. Was a		autopsy findings available completion of cause of
of Vital Records, be Physician: The law requirements the this certificate has been sment director, page 2 should to De Commodute.			,		autops perfor	med? death?	
tal Reco			26.PI	ace of Death (Check			
of Vital Ing Physician: After this certification of To Bo	examiner? Hospital: 1 Inpatie	ent 2 🗸 ER/Outpat				Residence 6 Oth	er:
Division of Vital Reconstant of Vital Reconstant of Attending Physician: The Jours after death. Filled in by the funeral director, page filled in by the funeral director, page		ry 28b. Time (ear) 1833 hrs	· · · · · · · · · · · · · · · · · · ·	Injury at Work? Yes 2 ✓ No	Driver motor	now injury occurred rcycle fixed object	t collision
Visior or Attend after death Director:	Pending 2 Accident Pending Investigation 28e Place of in	njury - At home, farm,	'-		28f. Location (S	Street and Number or I	Rural Route Number, City
Division spital or Attendii hours after death. meral Director: /	Suicide Could not be	jor Road / Highv			or Town, S Route 2 South	tate) nbound, Parole, MD	
		y knowledge, death o	occurred at the time	e, date and place, an	nd due to the caus	e(s) and manner as st and place, and due to	ated. the cause(s)
To the Hos within 24 h To the Fur	(Check only one) 2 Medical Examiner: On the basis of examiner and title of gertifier 29b Signature and title of gertifier	A A A A A A A A A A A A A A A A A A A		ense number		29d. Date signed (A	
			О.	C.M.E.		September 3, 2	2007
	30. Name and address of person who completed cruse of c	death (Item 23a)					
BOH	Susan Hogan MD. Assistant Medical E	xaminer 111 l	Penn Street, E	Baltimore, MD 2	1201		
Sta Registra	OFD A F ARRIVA	ar's Signature	Specific				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** РМ 31, 2007 4:30 August Myrtha Saint-Fort /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Magnolia Gardens Nursing Home Prince Georges Lanham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Hours Months Days 1 □ M 2 😡 F June 18, 1933 Haiti 74 082-40-3395 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exerci-10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 ☑ Yes 2 ☐ No Directo Prince Georges Glenarden Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 8617 Glenarden Parkway 20706 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify: ρ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Roselash Company 12 Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mesida Vieux Justin Pierre Paul 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15900 Penn Manor Lane Bowie, MD 20716 Joel Saint-Fort/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland National
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 9/4/2007 Laurel, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Juneral Service 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Months Cardiomyopathy /Medical Due to (or as a consequence of) Examiner Arteriosclerotic Cardiovascular Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year õ in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 🔀 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Lymphocytic Leukemia, Renal Insufficiency, should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Left Lung Mass Unspecified, Anemia, autopsy perform Respiratory Failure, Diabetes Mellitus 2 XNo certificate 1 ☐ Yes 25. Was case referred to medical examiner? **Director:** After this certific in by the funeral director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA မှ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Hospital or Attending 5 ☐ Pending investigation Injury 1X Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 9/2/2007 D01852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 Queensbury Road Hyattsville, MD 20781 Paul A. Devore M.D. 31. Date filed (Month, Day, Year) gistrar's Signature State **SEP 0 5** 2007

Registrar DHMH 17 Rev 1/2001 07-06780 Paula Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 30262

		1- For State Certifica Registrar	te of Death	,	Reg	. No.	0, 0020	
Physicia	n/	Decedent's Name (First, Middle,Last)			2. Date of Death Month	Day Year	3. Time of Death	
ા Exami		Paula Ann Smith		(D+)	September	1, 2007	0225 hrs	
		4a. Facility Name (if not institution, give street and number) 938 Wilmington Avenue	4b. City, Town, or Location Baltimore	n of Death		4c. County of Dea	itn	
	4	Social Security Number 6. Sex 7. Age (In yrs. last birth.)		der 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. E	Birthplace (State or	
Funeral Director		220-66-1281	Yrs. Months Days Hou		07/21/	1955 Fore	eign Maryland	
	ŀ	Usual Residence of Decedent	113.	<u>.</u>				
any		10a. State 10b. County 10c. City, Town of	r Location	**		10.0	10d. Inside City Limits	
nd show	اۃ	MD Balti	more .				1 X Yes 2 No	
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code		100	. Citizen of What Co	ountry?	
the N 3a or otified		938 Wilmington Avenue	21223			USA		
h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic O If Yes, specify Cuban, Mexica 			14. Race - Am White, etc.	erican Indian, Black,	
er deat	F	1 Yes 2 X No	1 Yes 2 X No specif	fu		Specify: V	White	
rs afte ural"	à	or Dates:	ecedent's Usual Occupation (Giv		ork done	16b. Kind of Busines		
2 hou	ompleted	d	uring most of working life. DO NC nager of Shippi	OT use retir	ed)		International	
5-0036 led within 7/ Hygiene. other than	du	12 Rec	ceiving		~	H	Paper	
5-0 led w Hygie I othe	ပ၂	17. Father's Name (First, Middle, Last)	į .		(First, Middle, Ma			
21215-0036 hould be filed within 72 ho and Mental Hygiene. is marked other than "na ritic event, the Medical Ex	Be	William Westman 19a. Informant's Name/Relationship (Type, Print) 19b	Mailing Address (Street and N	llian	Napolit	ano	ete Zin Code)	
D 2 shou and N 7 is n	٩	1.1.21	21 Knollwood Ro					
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and N Important: If item 27 is n injury or other traumatic	1	20a. Method of Disposition 20b. Place of	Disposition (Name of cemetery,		Date	20c. Location - City	or Town, State	
Baltimore, permit Pages 1 an Department of He Important: If ite		Motro	ry or other place) Crematory	Sep 20	t. 04,	Baltimore	Maryland	
	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses	22. Name and Address of Faci	ility	1.0			
Balti permit Departn Importi injury o		Ahomus & Allen	Barranco & Sor 195 Gov. Ritch	ıs, P	A. Seve	rna Park	Funeral Home	
hysician ^a -	1	23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	enter the mode of dying, such as	s cardiac o	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and	
Medical _xaminer		Immediate Cause (Final disease a. Hypertensive Atherosclerotic	Cardiovascular Disease				Death	
Xaiiiiici		or condition resulting in death) Due to (or as a consequence of):						
	<u>.</u>	Sequentially list conditions, if any, leading to immediate District for as a nunser, using a officer.		1				
	를	cause. Enter Underlying Cause						
ed nsit	Examiner	events resulting in death) Last Due to (or as a consequence of):						
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760, fcate be executed physician and the burial - trans	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		_		23d. Date of deliv	very	
587 stiffca ling pl	an/N	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ecto	opic pregna	ncy	Month	Day Year	
Box 687 e death certific the attending p	sician/	1 Yes 2 No 9 V Unknown Pregnant at time of death 5	Other (Specify)					
D.O. Be that the de- ned by the	Phy	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in	Part I.	23e. Did tol	pacco use contribute	to the cause of death?	
P.O.	ģ				1 Yes	2 No 3 F	Probably 4 🗸 Unknown	
rds, P.C requires that been signed 1	ompleted				24a. Was a		autopsy findings available to completion of cause of	
COI e law i e has b	I D				autops perfor			
of Vital Records, ng Physician: The law requir After this certificate has been s neral director, page 2 should	ပ	25. Was case referred to medical	26.Place of Dea	ath (Check		NO I	103 2 10	
/ita /siciar uis cer directe	o Be	evaminer?	utpatient 3 DOA Other	Nursir	g Home 5 1	Residence 6 🗸 0	ther: Scene	
n of Vi ding Physi After this funeral dir	-	27 Manner of Death 28a Date of Injury 28b.	Time of Injury 28c. Injury at W	ork?	28d. Describe h	ow injury occurred		
ion tendin eath. lor: A the fu	tior	1 Matural 5 Pending Investigation	1 Yes 2	No				
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Divis Hospital or A 24 hours after Funeral Dive	Certification:	4 Homicide determined (Specify)						
To th within To th compl	Medical	and manner stated.	29c. License numb			29d. Date signed		
	2	29b. Signature and title of Certifier	O.C.M.E.			September 2,		
(not	7	JW4	3.011.12					
1/2		30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 1	11 Penn Street, Baltimore	e, MD 2	1201			
	tate	20 Per stande Cincoture						
Regis		CED 0 4 2007 6	book					
DHMH 17 Rev 1/2	2001	OR	IGINAL			00	ME	

Amend #6 Per FH G872 10/12/07/2H Certificate of Death Reg. No. 2 0 0 7 30264 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician September 14, 6:30 PM 2007 George W. Tester /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Havre de Grace Harkord 4105 Webster Road If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** XXM 25 Days Hours 95 08/06/1912 Tennessee Director 201-03-2431 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Havre de Grace Harkord 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21078 U.S.A. 4105 Webster Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.

Is marked other than "natural", or Itel 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Construction Foreman Construction 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any linjury or other traumatic evonce. Mary Alice Mains William Stacey Tester ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Tester (daughter) 4105 Webster Rd., Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Deer Creek Cemetery 09/18/2007 Darlington, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility 2 Smith Funeral Home Part1. Enter the disease, Part1 lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final 10 Ihrive tailure **Physician** 3 Months disease or condition resulting in death) /Medical Due to (or as a consequence,of): Examiner Al Theimers Sugars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Yes 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ N'ATASULIA Dependant Diahetes Mellitis 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1□ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 1 Yes 25 No 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ater death. 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200048050 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
P(B) GShart Shukla, NO 15 Such Parke Street #400 Aberdeen MP 21001 reashart Shukla, MO 31. Date filed (Month, Day, Year) 32.Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 30265 State of Maryland / Department of Health and Mental Hygiene 17 Certificate of Death 3. Time of Death 2. Date of Death Year 1. Decedent's Name (First, Middle, Last) 2007 3:43A 3 Sept **Physician** 4c. County of Death Tyler Η. 4b. City, Town, or Location of Death /Medical 4a. Fecility Name (If not institution, give street and number) Prince Georges

9. Birthplece (State or Foreign Country) Examiner Cheverly

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Prince Georges Hospital 7. Age (In yrs. last birthday) Days Hours Min. 5. Social Security Number Months SC 1(**X**M 2□ F May 26,1931 Yrs. **Funeral** 76 250-42-2004 Director 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 1 Yes 2 No 10b. County death with the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If I tem 27 is marked other then "natural", or itams 23a or 28a-1 show eny injury or other traumatic event. The Modical Examination in Inditional angone. Suitland **Funeral Director** PG 10g. Citizen of What Country? Md. 10f. Zip Code 10e. Street and Number United States 20746 4628 Powell Lane 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: Specify: Black 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-0036 þ 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) Private College (1-4or 5+) Maintenance Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Wise Leatha Tyler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ravenell 19a. Informant's Name/Relationship (Type, Print) King Frederick Way Mariboro, Md. 2077 13801 Terri Tyler/daughter Upper Maribo

20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Md. 9/20/07 Ft. Lincoln Cem. 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service License 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Fatal Cardiac Arrhythmia Immediate Cause (Final Physician disease or condition resulting in death) Due to (or as a consequence of): /Medical Cardiovascular Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hypertension the death certificate be executed rattending physicien and I for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death IF FEMALE: Day Year Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown P.0. the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 Yes 2 No 3 Probably 4X Unknown þ Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No Completed 24a. Was an has page 2 1 Yes 2 X No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital or Attanding Physician: Medical Certification; To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 XEP/Outpatient 3 ☐ DOA 1 Yes 2 No 28d. Describe how injury occurred nerel Director; After this of filled in by the funeral dire 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 5 Pending 1 Yes Natural 28f. Location (Street and Number or Rural Route Number, City or Town, State) investigation 2 Accident death. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours a To the Funerel L 29a. Certifier (Check only 29d. Date signed (Month, Dey, Year) one) the 29b. Signature and title of certifier 9-14-07 Cheverly Mrd 20785 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

5

Registrar

State

tarista

2007

31. Date filed (Month, Day; Year)

3001 Hospetal

3 Registrar's Signature

07-06769 Mary Alice Thompson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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•		- For State	Cert	tificate of	f Death		Re	g. No.	
Physicia		tegistrar 1. Decedent's Name (First, Middle,La	st)				2. Date of Death		3. Time of Death
Exami	111/	MARY ALLEN THOME					Month August 31,	Day Year 2007	1238 hrs
LXaiiii		4a. Facility Name (if not institution, gir			4b. City, Town, or L	ocation of Dea		4c. County of I	Death
		Edmonston Road south o			Beltsville			Prince Ge	orge's
							La Day (Die)	1	9. Birthplace (State or
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days		Ain.	F	Foreign
Director		212 25 4065	M 2XF 57	Yrs		- Hours I N	05/06	/1950	Country) NC
	ŀ	Usual Residence of Decedent					1,5	- 10 N	
**************************************		10a. State 10b. County	10c. City,	Town or Loca	tion				10d. Inside City Limits
- -	1		00.	TTMTT				,	1 X Yes 2 No
and Fsho	ō	MD HOWARD		LUMBIA			- 146	g. Citizen of What	t Country?
faryl	ect.	10e. Street and Number			10f. Zip Code			g. Citizen oi whiai	Country
he N iffed	Director	7557 MURRAY HILI	ROAD #128		21406			UNITED	STATES
death with the Maryland or items 23a or 28a-f show any must be notified at once.		11. Marital Status	12. Was Decedent Ever in U.:				Specify Yes or No-		American Indian, Błack,
ath v tems	Funeral	1 Never Married 2 Marrie	Armed Forces?	lf '	Yes, specify Cuban	, Mexican, Pue	erto Rican, etc.)	White,	etc.
or in	Fu	3 Widowed 4 X Divorce	1 Yes 2 X No	1	Yes 2 X No	specify:		Specify:	BLACK
5-0036 led within 72 hours after bygiene. other than "natural", the Medical Examiner.	ρ		or Dates:	16a Decede	nt's Usual Occupat		of work done	16b. Kind of Busi	
10ur	8	15. Decedent's Education (Specify		. during r	nost of working life.	DO NOT use	retired)	At the second second	care or a real or and analysis of the second
72 1 ra ", u	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)					DDTTAM	12
03 ithin r th	ᇤ		1YR.	PRO	GRAMMER			PRIVAT	E
ed w ed w lygie othe	8	17. Father's Name (First, Middle, Las	t)				ame (First, Middle, M	Maiden Surname)	
21215-0036 uld be filed within 72 hours Mental Hygiene. marked other than "natur c event, the Medical Exam	B B	MAJOR B. ALLEN					CLANTON		
- 5 5 6 9	0	19a. Informant's Name/Relationship	Type, Print)	19b. Mailii	ng Address (Stree	t and Number-	or Rural Route Nun		
Short short and and matic		MARKETA ALLEN-JO	HNSON/DAUGHTER	911-	D ROYAL S	TREET	ANNAPOL	IS,MD 21	
re, MD 2 is 1 and 2 shoul of Health and In If item 27 is in		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of cer	metery,	Date	20c. Location - 0	City or Town, State
Tore ages 1:ant of H.		1 Burial 2 X Cremation 3	Removal Itom State	crematory or o					ATT A TOTAL
Page nent		4 Donation 5 Other Specia	y: MET	[ROPOL]	TAN CREM	ATORYO!	9/08/2007	ALEXA	NDRIA, VA
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other trains	10 14	20 Signature of Funeral Service Lice		22.	Name and Address	of Facility	RAL HOME	OF MARYL	AND, INC.
		1.7. 11 wes	kll		4308 SUT1	T.AND R	OAD SUI	TLAND, M	D 20746
ysician		23a. Part I. Enter the disease, or cor	plications that caused the death	. Do not enter	the mode of dying,	such as cardia	ac or respiratory arr	est, shock, or hear	Approximate Interval Between Onset and
Medical		failure. List only one cause on	each line.				333		Death
Examiner	1	Immediate Cause (Final disease or condition resulting in death)	Multiple Injuries	Δ.					
	-	or condition resulting in death)	Due to (or as a consequence of	π):		,	*		
	i.	Sequentially list conditions,	Due to (or as a consequence of	·U·			· · · · · · · · · · · · · · · · · · ·	~	
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of	и).			. 494		- L
	E E	(Disease or injury that initiated	Due to (or as a consequence of	of);					
ed ed	EX	events resulting in death) Last	4	•					
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'60, cate be ex physician he burial	edical	UNPENDED	AMENDED					1	
760, Treate be ex g physiciar the burial	≥	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcome of preg		0			23d. Date of o Month	Day Year
587 ertification		past 12 months?	1 Live birth	noth =		Ectopic pr	egnancy	Month	Day
of Vital Records, P.O. Box 687 in Physician: The law requires that the death certificate that been signed by the attending firector, page 2 should be detached for use as the property of the content of	Physician	1 Yes 2 No 9 V Unkno	4 Pregnant at time of de	eath 5	Other (Specify)			4	
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ires that the de signed by the de detached is	P	Part II. Other significant condition	s contributing to death but not a	resulting in the	e underlying cause	given in Part I.			
P.O. es that the igned by be detac	3	l'i					_ ¹ _ Ye	s 2 V No 3	Probably 4 Unknown
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OFC IW re as be 2 sho	픮						auto		eath?
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Division pital or Attentours after deatheral Director:] ≟	3 Suicide 6 Could r	28e. Place of Injury - At I	nome, farm, st	reet, factory, office	building, etc.	or Tours	State)	
ital O	er	4 Homicide determi	ned (Specify) Major Roa	ad / Highwa	ay		Edmonston	Road south of S	unnyside Avenue, Beltsville,
losp 4 hou fune		29a. Certifier 1 Certifying Phys	sician: To the best of my knowle	dge, death oc	curred at the time,	date and place	, and due to the cau	ise(s) and manner	as stated.
DIVI	Medical	(Check only one) 2 Medical Exami	ner: On the basis of examination	and/or investi	gation, in my opinic	n, death occur	red at the time, date	e and place, and d	ue to the cause(s)
To t To t	<u> </u>	29b. Signature and title of certifier	and manner stated.			ise number			ed (Month, Day, Year)
	2	A				.M.E.		September	1. 2007
		unes			1 0.0			Coptomber	., 200.
0 (5)		30. Name and address of person w	no completed cause of death (Ite	m 23a)					
			tant Medical Examiner	111 Penr	n Street, Baltim	ore, MD 2	1201		
	 State	01.5 1.51 1.01 1.5	32. Registrar's Signa	turg					
		. J. Date mod proprint Day, regit		A . M.	,				

			For State Registrar	State of M	Maryland		artment of F ertificate of		-	giene Reg. No. 20	07	30267
~	Physici		1. Decedent's Name (First, Middle, Las		Edison	Th	ompson		2. Date of De Septemb	per ^{Da} 4, 2	2007	3. Time of Death 2:00 PM
b	/Medio Examir		4a. Facility Name (If not institution, give	street and number				or Location of Death		4c. County	y of Death	
gr ²	Funeral Director	i i	5. Social Security Number 6. Social Security Number 262–26–3084	9x 7. A M 2□F	Age (In yrs. las 87	t birthday Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept 2	th (IV, Year) 3, 1919	9. Birthr Cour F 10	place (State or Foreign orida
	Maryland a-f show Ified at	ctor	10a. State 10b. County Maryland Prince G	eorge's	10c. City, 7	Town or L		[yattsvil	le			0d. Inside City Limits 1 Yes 2 No
	with the 3a or 28 it be not	I Dire	10e. Street and Number 5821 Maryhurst D	rive			10f. Zip Code	20782		10g. Citizen of	What Coul	ntry?
9036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	s? ⊻ No	13.	Was Decedent of H If Yes, specify Cub 1 □ Yes 2 ☒ No		pecify Yes or No o Rican, etc.)	14. Ra Bla Specii	ce - Americ ick, White, fy: W	
15-0	iin 72 he n "natu Medical	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed) College (1-4o		16a. Dece (Give life.	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of wor d)	king	16b. Kind of E	Business/In	dustry
Maryland 21215-0036	be filed with tal Hygiene of other than than event, the N	Be	17. Father's Name (First, Middle, Last)	4+	(5+)		Minister/	18. Mother's Nan		, Maiden Surna	civate me)	9
aryla	2 should be tand Mental I is marked of aumatic eve	7	Jasper Quincy Th	Type. Print)	-		ing Address (Street	l and Number or Ru		er, City or Town		
	1 and 2 Health a em 27 is		Rachel Thompson 20a. Method of Disposition	(Wife)	20b. Plac		Maryhurs		Hyatts	VILLE, I		
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of the control of th)	e	Linc	osition (Name of ematory or other pla coln Cemet 22. Name and Addre 9013 Anna	ery 9/7/	2007 ndon/Hal	Brentwo le Funei	ood, l	MD
٧			23a. Part. Enter the disease, or companion shock, or heart failure. List only	dications that caus	ed the death.	Do not er					20700	Approximate Interval Between
	Physician /Medical Examiner	-	mmediate Cause (Final disease or condition resulting in death)	a. Ather			Heart Dis	sease				Onset and Death
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,092	ate be executed nysician and he burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a	as a conseque	nce of):						
Division or Vital Records, P.O. Box 68	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal d at time of dea	eath 3	□Ectopic pregnanc □ Other (specify) _	ey			ate of deliv	ery Day Year
ds, P.	uires that signed by d be deta	by	Part II. Other significant conditions of Cerebrovascular									he cause of death?
Recor		Completed	Gastrointestina	L Bleedin	g						prior to co death?	opsy findings available impletion of cause of
Viita	slcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		2/0	oti aci pos Oti	her	ath (Check only			
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Divis		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building,	etc. (Specify)		treet, factory, office		City or To	wn, State)		al Route Number,
	To the Hospital or All within 24 hours after of To the Funeral Directompletely filled in by	Medical (29a. Certifier 1 (Check only one) (Check only one) 1 Certifying Ph 2 Medical Example 1	ysician: To the bes niner: On the basis and manner	of examinatio	edge, dea n and/or	ath occurred at the t investigation, in my	opinion, death occi	e, and due to the urred at the time	, date and place	e, and due	to the cause(s)
	To the within 2 To the complex	M	29b. Signature and title of certifier	Inh &	GNI		29c. Licens	se number 058776		29d. Date sign Septem		
R	(6)		30. Name and address of person who Doris Bustos, M	completed cause of	f death (Item 2	3a) (Type	e, Print)	, Suite 2	213, Wasi	hington	DC 2	0017
	C+	ate	31. Date filed (Month, Day, Year)	32. Regis	strar's Signatu	e .	-					

DHMH 17 Rev 1/2001

Registrar

			for State Registrar	Otato on with	ai y iai i	-	rtificate of			Reg	_ 20 (17	30268	
ī	Physicia	an	1. Decedent's Name (First, Middle, I	·						ate of Death onth	Day	Year	3. Time of Death	
	/Medic	al	Charles A		kne1	<u> </u>	4b. Cify, Town, o	r Location		tembe	4c. County	2007	10:00 A	_
	Examin	er	7431 Willow H				Fred				1	eder	ick	
	Funeral				e (In yrs. 85	last birthday, Yrs.	If Under 1 Year Months Days		er 24 Hrs. 8. Da	ate of Birth Ionth, Day,			lace (State or Foreign atry)	
	Director		Usual Residence of Decedent	ж –	0.5	113.			Dec	. 10,	1921	New	York	_
	how thow	L	10a. State 10b. County		1111	y, Town or L						1	0d. Inside City Limits	
	he Ma 28a-f s otifled	ecto	Maryland Frederi	ck	Fre	deric				10	g. Citizen of W	/h =4 O=11	1 ☐ Yes 2 ☒ No	TOO
	a or 3	Funeral Director	10e. Street and Number 7431 Willow Road				10f. Zip Code	1702		10	g. Citizen of W US		nry ?	
	r death	inera	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic (Origin? (Specify Yo	es or No-		- Americ	an Indian,	-
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 √ Yes 2 □ I If Yes, Give Year or Dates:	ww WW		1 □ Yes 2 No	Specia			Specify:		ite	
3	'2 hou natura ical Ex	ted	15. Decedent's	 Education		16a. Dece	dent's Usual Occup	ation	ant of working	11	l 6b. Kind of Bu	siness/Inc	dustry	
7	rithin 7	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5	i+)		kind of work done DO NOT use retired ancial Ma				US Gov	arnm	ent	
7	filed w Hygie ther ti	S	17. Father's Name (First, Middle, La			1 1116	anciai na		ther's Name (First	, Middle, Ma				_
0	uld be Aental rked o tic eve	To Be	Charles Walt	,	ne11			Mar	y E1	len	Philli	ps		
9	2 short and 1 is ma		19a. Informant's Name/Relationship	(Type. Print)			ng Address (Street							•
ט .	1 and Health em 27 other to		Lorina Tocknell/ 20a. Method of Disposition	Wife	20b. F		Willow R		Cottage		rederic Oc. Location -			_
	Pages nent of I int: If ite		1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				osition (Name of matory or other place	!	9/17/20			•		
	permit. F Departm Importar any Injur		21. Signature of Funeral Service Lic		JSLE		Cremator 2. Name and Addre				Funeral		~	-
	8 9 E E 8	-	1 AGGUIL	Win			521 Oposs					MD_{2}		_
			23a. P. Z. Enter me disease, o co k, r art failure. List Immediate Cause (Final	mplications that caused up the cause on each li	the deat ne.	h. Do not en				iratory arres	st,		Approximate Interval Between Qnset and Death	
F	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	aconseq	Casu uence of):	tent	SCV	nervus			-	NOUNS.	_
	Examiner		Sequentially list conditions	b										
- Seg	sit ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseq	uence of):								
5	execu n and ial-trar	Exar	that initiated events resulting in death) Last	c Due to (or as	a conseq	uence of):								-
,00%	tificate be executed g physician and as the burial-transit	lical		d										_
5	ding p	/Mec	IF FEMALE:	23c. If yes, outcome	of pregna	ancv					OOA Date	6 -1 - 1 - 1		-
9	To the Hospital or Attending Physiciani. The law requires that the death certificate be executed within 54 hours attendent. Within 54 hours attendent. To the Funeral Director. After this certifi¢ate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 □Live birth 4□Pregnant at	2 Feta	death 3	□Ectopic pregnancy □ Other <i>(specify)</i> _	/			23d. Date Mor		Day Year	
2	at the I by the stache	hys	9 Unknown	9□Unknown										_
6	signec	by	Part II. Other significant conditions	contributing to death b	ut not res	_	inderlying cause giv	en in Par	11. 2	3e. Did toba			ne cause of death?	
5	w requ	letec	- Terwhoer	TO POOL	1-0				24	4a. Was an			psy findings available	-
ב ב	The la ite has	Completed								autopsy perform	ed?	rior to colleath?	mpletion of cause of	
	ertifica ctor, p	Be C	25. Was case referred to medical examiner?						ice of Death (Che				20110	-
5 7	Physic this c	P	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatie		ER/Outpatie	nt 3 DOA Oth	41	Nursing Home 5		nce 6 Othe		(y)	_
5	th. ; After e funer	tion	1 Natural 5 Pending 2 Accident investigat	(Month, Da	y Year)	Injury	Wor	k? Yes 2		escribe nov	v injury occurr	eu		
2	r Atter er dea rector	Certification:	3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of injude	ury - At ho c. <i>(Specif</i>	ome, farm, st	reet, factory, office			ocation (Stre		er or Rura	I Route Number,	-
2	pital o urs aft eral Di illed ir		29a, Certifier 1 Certifying	Physician: To the best				mo doto	and place and de	is to the ear			Laka d	_
:	of the Hospital or Attending Physiciani, within 24 hours after death. To the Funeral Director: After this certification properties of the funeral director, and the funeral director director, and the funeral director director, and the funeral director director, and the funeral director director, and the funeral director direc	Medical	(Check only 2 Medical Ex	aminer: On the basis o and manner sta	f examina	ition and/or in	nvestigation, in my o	opinion, o	leath occurred at t	the time, da	te and place, a	and due to	tated. the cause(s)	
:	To the within To the comp	Me	29b. Signature and title of certifier	2 450	A-	7	29c. Licens	e numbe	1621	29	d. Date signed	(Month,	Day, Year)	
	4		y Hic	- 1100		11mm		14	104	19	16	0	11.0	
U	11		30 Name and Iddress of person wh	o completed cause of d	eath (Iten	1 23a) (Type,	Print) ON	ins t	on Pr	me.	Fred	ne	n (1702	4
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	r's Signa								2110	-

State Registrar SEP 0 7 2007 > See & April 1

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. N. 2007 30270 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day September 2, **Physician** CATHERINE 2007 2:40 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Villa Rosa Nursing Home Prince Georges Mitchellville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 1 🗓 F 82 Director 213-26-8536 20, 1925 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Marylan Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notifiled at 10d. Inside City Limits 1X Yes 2 No Director Maryland Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7308 Quartz Terrace 20720 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: \$ Specify: 3 X Widowed 4 □ Divorced **Black** Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Home Maker permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other t any injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oscar Sharp Vina Johnson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7308 Quartz Terrace Bowie MD 20720 Stella McKelvin/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ebenezer Baptist
Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/7/2007 Goochland, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METACTUTIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause (Disease or injury that initiated events resulting in death) Last death certificate be executed burial-trans Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the l as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy fo in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Inknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1□ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 2P No P 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 24 29b. Signature 29c. License number and title of certifier 29d. Date signed (Month. Dav. Year) 17226 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Feldman M.D. 3800 Lottsford Vista Road Mitchellville, MD 20716 Registrar's Signature 31. Date filed (Month, Day, Year) SEP 0 5 2007 Registrar

amend line 23a-c perPlease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 8/30/07 dlwState of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** P^{M} 22 2007 6:06 Robert Allen Taylor Jr Aua /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days 48 249-82-6071 Jan 07,1959 South Carolina Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sham any injury or other traumatic event, the Medical Euler. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD Anne Arundel Severna Park 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21146 4 Lennox Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No 1982 If Yes, Give Year or Dates: 2002 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2□No 1982-1 Never Married 2 Married 1 ☐ Yes 2 🛣 No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced 2002 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Computer Networking Co-Owner of SG Data 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Suzonne Stewart Robert Allen Taylor Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4 Lennox Avenue, Severna Park, Maryland 21146 Toby Celia Taylor/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 24, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility 21. Signaline of Fruetal Servi Barranco & Sons, 495 Gov. Ritchie P.A. Hwy, Severna Park Funeral H Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 450199 **Physician** /Medical u to (or asra consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence Physician/Medical Examiner Intracerebral/Hemorrhage The law requires that the death certificate be executed use as the burial-transi and Due to (or as a consequence of) or Vital Records, P.O. Box 68760, attending physiciar IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Por in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 2 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → 24a. Was an page 2 s autopsy perform 1∐ Yes Physician: 26. Place of Death (Check only one, Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Heatient 1 ☐ Yes 2 ☐ Mg 2 ER/Outpatient 3 DOA ို 28d. Describe how injury occurred 28a. Date of Injury Manner of De Certification: the Funeral Director: After mpletely filled in by the funer 1 Jural (Month, Day Year) Injury Division Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide 24 hours rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| edical Examiner: On the transition and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 2 dical Exam 29d. Date signed (Month, Day, Year) 29b. Signature and title of sertifig 2 77 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) whe 31. Date filed (Month, Day, Year) AUG 3 0 2007 Registrar

		For State Registrar	State of Ma	rylan		artment of I <i>rtificate of</i>		id Mental Hy	/giene Reg. No	2007	30272
Physicia		1. Decedent's Name (First, Middle, Last) F. Jose L		T	Tainer		•	2. Date of D Month			3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give si	at The	L	alce	4b. City, Town,	Sbury	Death	4	County of Deat	· (C)
Funeral Director		216-14-/161	M 2∑F	93	last birthday) Yrs.	Months Days		Hrs. 8. Date of B (Month, D) 7-29-1	ay, Year)		nplace <i>(Stat</i> e or Foreign untry) yland
with the Maryland a or 28a-f show t be notified at	Director	Usual Residence of Decedent 10a. State 10b. County MD Wicomico			y, Town or Lo lisbur	У					10d. Inside City Limits 1X Yes 2 □ No
eath	Funeral Dire	10e. Street and Number 605 Crestview Lane 11. Marital Status 1 □ Never Married 2 Married	2. Was Decedent E Armed Forces?		S. 13.	10f. Zip Code 2180 Was Decedent of f Yes, specify Cul		n? (Specify Yes or N Puerto Rican, etc.)	USA	izen of What Co 14. Race - Ame Black, White	rican Indian,
nin 72 hours after d "natural", or Item Medical Examiner	Completed by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	1 ☐ Yes 2 Note of the second		16a. Dece	1 ☐ Yes 2X No dent's Usual Occu kind of work done DO NOT use retire	pation	f working	16b. K	Specify: Wh	
be filed within 72 hand Hygiene. So other than "natuevent, the Medical	Be	17. Father's Name (First, Middle, Last)	5+ 5+	-		maker	l	Name (First, Middle	e, Maiden	,	
permit. Pages 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any injury or other traumatic event, the Medions.	To	Curtis W. 19a. Informant's Name/Relationship (Type Paul I. Trainer -	,	Lon	19b. Mailir	-		or Rural Route Num Salisbur	ber, City o		(ip Code)
Pages 1 a ment of Hee ant: If item ury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	0	Place of Dispo remetery, crer	sition <i>(Name of</i> matory or other pla Cemetery	ace) 9.	Date -4-2007	20c. Le	ocation - City or	
permit. Depart Import any Inj once.		21. Signature of Funeral Service License			70		in Stre	Bounds Fu et, Salis	bury		
Physician /Medical	Ų Į	23a. Part1 Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death							
cate be executed by physician and physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a								
ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome p 1 □Live birth 2 4 □ Pregnant at t 9 □ Unknown	Feta	Ideath 3□]Ectopic pregnand]Other (specify) _	ey .			23d. Date of del Month	ivery Day Year
w requires that the de been signed by the s should be detached to	ρ	Part II. Other significant conditions conditions. Dialectes	mel	lei	tus		ven in Part I.				the cause of death?
	Completed	Essential	2 Hey	ser	ten	tern		24a. Wa auto pen 1∐ Yes	opsy formed?	prior to death?	topsy findings available completion of cause of
ysiciar s certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	ospital: 1 ∏ Inpatien	t 2 🗆	ER/Outpatier	t 3 DOA Ot	her:	Death (Check only		6 MOther (Spec	in Hespice
r Attending Physician: er death. rector: After this certifici by the funeral director,	Certification: T	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	M 1	ıryat ork?]Yes 2 ☐ No	28d. Describe	how inju	ry occurred	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi		4 Homicide determined	28e. Place of injurbuilding, etc.	(Specif	y) 	•		City or To	own, State	e) 	ral Route Number,
n 24 hc he Fun pletely	Medical	29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To With To	Σ	29b. Signature and title of certifier	a. Bel	la	a, The		se number 2 9 5 0	5		ite signed (Mont	h, Day, Year) 2 - 07
Sta	to.	30: Name and address of person who core GREGORIO M. B 31. Date filed (Month, Day, Year)	•	M.D	1530		BERRY	DR. SAL	ISBU	RY, M	D 21801
Sta	τe	31. Date filed (Month, Day, Year) SFP 0 4 20	107	_ 3.70	An a	100					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #18 Per FH G8/2 10/04/07 JH

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Cotember /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs 8. Date of Birth (Month_Day, **Funeral** yrs. last birthday, 9. Birthplace (State or Foreign 2 🗆 F Yrs. Director 10c. City, Town or Location 10d. Inside City Limits or 28a-f show notified at show 1 Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Never Married Married Baltimore, Maryland 21215-0036 2XNo Specify 3 Widowed 4 Divorced the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Sporgary (0-12) College (1-4or 5+) Hygiene. marked other Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, once. Be **Blanche** 2 (Street and Number or Rural Route Number 19b. Mailing Address Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (3 Removal from State 5 Other (Specify) permit. uneral Service Licensee 21. Signature 23a. Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: detached for use 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\sum \) Nursing Home 2 No 1 ☐ Yes Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) William, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Chestertown, M.D. Washington

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2007

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			Certificate of Death	Reg. No.	0027
	Physician	1. Decedent's Neme (First, Middle, Last)		2. Dete of Deeth Amonth Dey Year	3. Time of Death
No.	/Medical	ANUA B. WEBB		ANGUST 30, 2007	
J	Examiner	4a Fecility Neme (If not institution, give street end number)	4b. City, Town, or Lo	- A	
		Kunton Health of Denten	nirthday) If Under 1 Year If Under 24 Hrs.		
	Funeral Director	5. Social Security Number C21- 12-8598 1 M 2 F 7. Age (In yrs. lest be secured by 10 M 2 F 8 5	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Year) 9. Birth Co	thplace (State or Foreign buntry)
	and **		wn or Location		10d. Inside City Limits
	Mary fah	DE KENT HO	ARRINGTON		1 ☐ Yes 2 No
	Tec 188	10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Co	puntry?
	witer death with the Mark terms 23a or 28a-fa	231 Fox Hunters Rd	19952	4.5	A .
020	ges 1 and 2 should be filed within 72 hours efter death with the Maryland it of Health and Mental Hygiene. If flem 27 is marked other than "natural", or items 23a or 28a-f show or other traumetic event, the Medical Examiner must be notified at or other traumetic event, the Medical Examiner must be notified at or Other traumetic event, the Medical Examiner must be notified at	3 Widowed 4 □ Divorced If Yes, Give Yeer or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ★ No Specify:	pecify Yes or No- Pican, etc.) 14. Race - Ame Black, Whit Specify:	
0	2 hor	15. Decedent's Education 16	a. Decedent's Usual Occupetion	16b. Kind of Business/	Industry
21215-0020	permit. Peges 1 and 2 should be filed within 72 hours eft Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or any Injury or other traumetic event, the Medical Examples. To Be Completed by F	(Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired) Homewaker	and and H	ome -
0	Hygid Hygid ent, 1	17. Father's Neme (First, Middle, Last)		e (First, Middle, Maiden Surname)	
Maryland	Mental H Mental H arked off To Be	Russell J. Brown	Beulo	ah morgan	
ary	shou nd M mari		b. Mailing Address (Street end Number or Rure		Zip Code)
Σ	alth a 27 le	VIVIAN D.11 DAUGHTER 3	480 Vernon Rd, H	PARRINGTON, DE	19952
ē,	of Hein Item othe	20a. Method of Disposition 20b. Place	of Disposition (Neme of ery, crematory or other place)	Date 20c. Location - City or	
Baltimore,	Pege vent ort: if iry or	Tos-Burial 2 U Cremation 3 L Hemoval from State ,i		9-2-07 HARRINGTO	N. DE
alti	mit.	21. Signature of Funeral Service Licens	22 Hame and Address of Facility		
m	Depa Impo any is	Kandowy Moure	17 Satisfanda D	ergar, MD 2162	9
2	-	23a. Part1. Enter the dise , or complications that caused the death. Do shock, or heart feilur. List only one cause on each line.	not enter the mode of dying, such as cardiac of	or respiretory arrest,	Approximate
1	Physician	snock, or near reliurar List only one cause on each line.			Interval Between Onset and Death
7	/Medical	Immediate Cause (Final disease or condition resulting in death) a. Pueum	ORILA	!	3 have
	Examiner	, roseming in dealing	consequence of):		ODIT
				1	
	icete be executed physician end s the burial-transit	Sequentially list conditions,	consequence of):		
60,	be ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.			
68760,	ficete be physicia se the bu		consequence of):		
×	ding p	d			
Bo	ettend for us				
P.O.	d by the ettend letached for us	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23b. Did tobacco use contribute	
	signed b	HLZHOIMER'S DEMISNI	-M-	1 □ Yes 2 X No 3 □ Pr	robably 4 Unknown
Vital Records,	v requestration should			performed?	Were autopsy findings available prior to completion of cause of death?
æ	The lay ata has paga 2				1 □ Yes 2 □ No
tal	certifical rector, p	25. Was cese referred to medical	26. Place of Death	h (Check only one)	
\geq	Physician: this certific rel director, To Be (exeminer? 1 Yes 20 No Hospital: 1 Inpatient 2 ER/O	Other	me 5 Residence 6 Other (Spec	cifv)
n of	ding Phy. h. After thi funerel		Time of 28c. Injury at 19 Work?	28d. Describe how injury occurred	
sio	Attending or death. Sctor: After by the fune fill cation	2 Accident investigation	M 1 Yes 2 No		
Division	tal or Attending P rs after death. al Director: After ied in by the funer. Certification:	4 Homicide determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	 Location (Street and Number or Ru City or Town, State) 	iral Route Number,
	lospital of thours a uneral Day filled i	20a Cariffice 1 Cantilla The Cariffic The Ca		and due to the/-> ·	
	T % T 8	29a. Certifier 1 Certifying Physicien: To the best of my knowledg. (Check only one) 4 Certifying Physicien: To the best of my knowledg. Check only one and manner stated.	 death occurred at the time, date and place, and/or investigation, in my opinion, death occurred 	and due to the ceuse(s) end manner as ed at the time, date end place, and due	to the cause(s)
	within To the comple	29b. Signature and title of confiler 200	29c. License number	29d. Date signed (Montl	h, Dey, Yeer)
	⊢ ≯ ⊢ ō	Ma tra alle mo	D35284	8/31/07	
		30. Name and address of person who completed cause of deeth (Item 23e) ANONOTH ALLEN MO 21	(Type Print)	0151107	
		AND NITH ALUST MAD DI	9 S. Washaraton	St Caston me	21601
	State	31. Date filed (Month, Sur Year) 4 2007 32. Registrar's Signature			
	Registrar	THE THE PARTY AND ADDRESS AND	and the same of th		

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Doubleton Name (First, Marsh, Lase) Doubleton Name (First, Marsh,				For State Registrar	State of Maryla	nd / Depar <i>Cert</i> i	tment of H	lealth and N Death		gien 2007	30275
Proposed Proposed		Physic	ian	1. Decedent's Name (First, Middle, Li					2. Date of Dea	ith	3. Time of Death
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Director Director			4				-		0 D-1(D'4)		TICKAET
Usual Residence of December Usua	Н							Hours Min_	(Month, Day	, Year)	Country) . 1
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The second property of the second property of		arylar how	5	,			3				10d. Inside City Limits
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Nicole Cristopha" Mother G27 Setters on St. Salisbury Md.	<u>a</u>	id be lental ked c		Dwight Lee	Williams			_	4 1	Λ 1	ctopher
20a. Method of Disposition Date 20c. Location - City from State 20c. Place of Disposition Plants 20c. Location - City from State 2	ary	and M				19b. Mailing	Address (Street a				
Column C		and 2 ealth n 27 i		Niccole Christoph	ier/mother	62-	7 Jest	erson S	st. So	alisbury	Md. 21804
Physician (Nedical Examiner Physician Physician (Nedical Examiner Physician Physician Physician (Nedical Examiner Physician	ore					Place of Dispositi cemetery, cremat	on (Name of tory or other place	e) [
Physician (Nedical Examiner Physician Physician (Nedical Examiner Physician Physician Physician (Nedical Examiner Physician	Ë	tmen tant:		4 □ Donation 5 □ Other (Special	(y) Sa.	-			/2007	Salisbury,	Maryland
Physician Medical Examiner 23. Part Enter the disease, or complied/most that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inferior labely and the part of the par	Bal	Depar Import		21. Signature of Funeral Service Lice	nsee	Hol	lame and Address	s of Facility Ineral Ho	me PA		
Physician (Medical Examiner) Physic				23a Part 1 Enter the disease or com	unliestions that caused the deep	501	Snow Hi	<u>11 Rd. S</u>	alisbury	, Marylan	
Due to (or as a consequence of): Same S		Diamatata .		SHOCK, OF HEART TAILUTE. LIST ONly	one cause on each line.		are mode or dying	, such as cardiac o	or respiratory arr	est,	Interval Between
Sequentially list conditions. Due to (or as a consequence of): Due to (or	<i>i</i> '			disease or condition	a. Pre	matur	TY				2 hr 25mi
The state of the s		Examiner				dence or).					
Section Part 10 10 10 10 10 10 10 1		D =	ner	Sequentially list conditions, any leading to infraediate cause. Enter Underlying		uarios of):					
Section Part 10 10 10 10 10 10 10 1		ecute and trans	ami	that initiated events							
FFEMALE: 23b. Was decodent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1	90,	cien a		resulting in death) cast	Due to (or as a conseq	uence of):					
FFEMALE: 23b. Was decodent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1	387	physi physi s the t	dic		d						
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25. Was case referred to medical examiner? 1	'n.	as tha gned se dei	by P	Part II. Other significant conditions of	contributing to death but not res	ulting in the unde	rlying cause giver	n in Part I.	23e. Did tob	acco use contribute	to the cause of death?
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25. Was case referred to medical examiner? 1	ec .	law r las be	ple								autopsy findings available
29a. Certifier (Check ority one) 29a. Certifier (Check ority one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed can be of death (Item 23a) (Type, Print) Kenneth Keys 2003 Medical Parkway Apparoal is MD 21401	<u> </u>		S						perform	ned? death?	244
29a. Certifier (Check ority one) 29a. Certifier (Check ority one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed can be of death (Item 23a) (Type, Print) Kenneth Keys 2003 Medical Parkway Apparoal is MD 21401	<u> </u>	certifi	Be	examiner?	Hospital:		1 -		Check only one	θ/	
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Kenneth Keys 2003 Medical Parkway Annapolis MD 21401		s efte s efte al Dir	Cert	4 Homicide	building, etc. (Specify	()	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town	, State)	Table Hombon,
Kenneth Keys 2003 Medical Parkway Annapolis MD 21401		hour uner			ysician: To the best of my kno	wledge, death oc	curred at the time	, date and place, a	ind due to the ca	use(s) and manner :	as stated.
Kenneth Keys 2003 Medical Parkway Annapolis MD 21401		the H the F nplete	Medi		and manner stated.	lion and/or invest	igation, in my opi	nion, death occurre	ed at the time, da	ite and place, and di	e to the cause(s)
30. Name and address of person who completed calle of death (Item 23a) (Type, Print) Kenneth Keys 2003 Medical Parkvay Annapolis, MD 21401	, ,	0 1 × 10	<	29b. Signature and title of certifier	(1) -11	0 0					
Kenneth Keys 2003 Medical Parkway Annapolis MD 21401	9	10		1 enrec	Key Hil	inde	-	3066	5	8/22	100)
Aenneth Keys 2003 Medical Parkway Annapolis,MD 21401	(M.	- 1								
State 31. Date filed (Month, Day, Year) 2007 32 Registrar's Signature		Sta		31. Date filed (Month, Day, Year)	107 3 Pegistrar's Signa	y Annapo	DLIS,MD	21401		1000	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year Physician 5007. 1602 6 2007 Chester Thomas Yates /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** REGISHAL MEDICAL CENTER NICEMICO SALISBURY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□ F 1/8/1920 RI Director 039-10-5487 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 TV No Director MD Worcester Ocean Pines 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22 Ocean Parkway 21811 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" — ... any Injury or other trainment. 1 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Government Management Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Yates Elizabeth Moore ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah List / daughter 22 Ocean Parkway, Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Frankford, DE Cape Henlopen Crem. 9/7/2007 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, MD 21811 call art1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lest only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fina disease or condition resulting in death) Physician SEPTIC SHOCK /Medical Due to (or as a consequence of): Examiner ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural Injury within 24 hours after users.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier M.D. Ph.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. CARROLL ST. BA 10+1 15M457 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 10f per fb 9871 9-21-07 vt
State of Maryland / Department of Health and Mental Hygiene 2007 30277 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Q Physician** Day Year ARMstrong David 11:45 A M 07 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore NIA Elmora If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) **Funeral** Days Hours Year Months 1 M 2 □ F 220.64.065 MD Director 09/08 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 13a ltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 Wenye Elmora Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify à Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chef T000 utharade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be #. Spence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto Elmora Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 3 Removal from State 1 Burial 2 □ Cremation Windsor Mills, MD Memorial Park 4 □ Donation 5 □ Other (Specify) 09/20/07 22. Name and Address of Facility Vaugus C. Greene Functor SVCS 21. Signatur of Funeral Service Licensee Road Baltimore MD 2/2/2 4905 York 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 No 3 Probably 4 Jonknown 1 ☐ Yes Completed 24b Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No After this certificate 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 👿 No 2 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 □ Yes 2 □ No 2 Accident d in by the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in 1 PCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9/19/07 D28166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5010. YORK Rd, Balte. MD. 21212 Aye المانعا MD 31. Date filed (Month Day, Year) 32. egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

07-07161 Philip Alepa Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

піір Аіера	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2007 3027
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year
J	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	156-54-1453 X M 2 F 50 Yrs. Months Days Hours Min. Nov. 19, 1956 New York
v any	Usual Residence of Decedent 10a. State
the Maryland a or 28a-f show iffed at once.	
th the Maryland 23a or 28a-f sho notified at once	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 X Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc.) 14. Race - American Indian, Black, White, etc.
rs after of	3 Wildowed 4 Divorced in res, Give Year 11 Yes 2 No specify: Specify: Specify: 15 Page 14 Page
21215-0036 uld be filed within 72 hours aff Mental Hygiene. marked other than "natural" c eyent, the Medical Examing	Elementary/Secondary (0-12) College (1-4 or 5+)
21215-0036 uld be filed within 72 h Mental Hygiene. marked other than "n e eyent, the Medical E To Be Complete	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
21215 ould be file d Mental H s marked it event, t	Philip Alepa Doris Jovanovic
ore, MD 2 es 1 and 2 shou of Health and I fritem 27 is r ther traumatic	Philip Alepa / Father 330 West Ivy Lane Englewood, NJ 07631
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental lant: If item 27 is marked or other traumatic event, To Be	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Cal vary Cemetery Cal vary Cemetery 20b. Place of Disposition (Name of cemetery, crematory or other place) Cal vary Cemetery 9/20/2007 Queens, New York
Baltimore, permit. Pages 1 ar Department of Her Important: If ite injury or other tr	21. Signature of Funeral Service Licensee Kimberly Davidson 22. Name and Address of Facility 5305 Harford Road
Physician	Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part I. Enter the dise let of complications that cause Inc. In. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and
/Medical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Between Onset and Death Due to (or as a consequence of):
	Sequentially list conditions.
led nisit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
executed an and all - transit	
60, ate be execu bhysician and bunial - tra	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
Box 68760, death certificate be executed he attending physician and of for use as the burial - transit vvsician/Medical Ex	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)
D. Box 687 t the death certific by the attending p ached for use as th Physician/	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ires that the signed by the detached	
Division of Vital Records, P.C rale or Attending Physician: The law requires that its after death. al Director: After this certificate has been signed led in by the funeral director, page 2 should be detained in by the funeral director, page 2 should be detained in by the funeral director.	24a. Was an autopsy findings available autopsy findings available prior to completion of cause of performed?
tal Reccion: The certificate ector, page	
F Vital Physician r this certi al director	1 V Yes 2 No inpatient 2 V ERVoutpatient 3 DOA 4 Nuising Home 5 Residence 6 Other.
ion of \rightarrow teath. tor: After th the funeral	27. Manner of Death 1
Division o spital or Attending tours after death. neral Director: After filled in by the fune	Accident Investigation Suicide 6 Could not be determined (Specify) River Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Chester River - Buoy 37A, Chestertown, MD
hou bai	
To the Ho within 24 To the Fu completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title pf certifier 29c. License number 29d. Date signed (Month, Day, Year)
	O.C.M.E. September 15, 2007
25	30. Name and address of person who complet d cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Stat Registra	

State of Maryland / Department of Health and Mental Hygien 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

30279

			1 - State Registrar			Cer	rtificate of	Death		Reg. No.	-001	00213	
	p	6 V	1. Decedent's Name (First, Middle	, Last)						2. Date of Death Month Day Year 3. Time			
Physician			SAMUEL		J	ABRAMS				September 16		23:12 M	
9	/Medi		4a. Facility Name (If not institution	give street and num	nber)			ОФІС		County of Death			
	Exami	ner		_						40.	County of Beatin	N/A	
			5 inci Hospital o		7. Age (In yrs.	lo at histhelo.	Baltimo		C Data of D	inth	0.00		
%	Funeral		,	6. Sex 1 M 2 □ F		Yrs.	Months Days	Hours Min.	8. Date of B (Month, D	Day, Year)	9. Birtin	place (State or Foreign	
	Director		215-28-2222		78	113.			10/2/	//1928	8	MD MD	
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ootion					104 1-14-04-11-14-	
	iryla shov	_										10d. Inside City Limits	
	a-f	양	MD BAL	TIMORE	BA	LTIMOR	E					1 ☐ Yes 2 No	
Abrams	h th	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cour	n of What Country?	
	death with the Maryland ms 23a or 28a-f show r must be notified at	E D	7505 PARK HEI	GHTS AVENU	JE			21208			USA		
	ns 2	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.	S. 13. V			ecify Yes or N	lo- 1	14. Race - Americ		
4	iter o	Ē	1 ☐ Never Married 🕻 Marri	Armed For	ces?	I .		Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Black, White,		
38	hours after tural', or ite	Š	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	е	1	I□Yes 2 X □No	Specify:			Specify: WHI	TE	
ન્યું છે	hou hou	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business							nd of Business (In	duotni		
युं छ	"na	<u>e</u>	(Specify only highes	t grade completed)		(Give	kind of work done OO NOT use retire	during most of work	ing	100. Kii	id of business/in	dustry	
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	filed v Hygie other t	ပ္ပ					SURGEON					ICINE	
	al H	Be	17. Father's Name (First, Middle,					18. Mother's Nam	e (First, Middl	e, Maiden :	Surname)		
a E	Mental Mental arked o	ြို	Μ.	JAC0B		ABR	AMS	MINNIE				KESSLER	
known re, Maryl	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me		19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailin	g Address (Street	and Number or Rui	ral Route Num	ber, City or	r Town, State, Zip	Code)	
ğ Z	od 2 Ilth a 27 is		ELAINE ABRAMS	/ WIFE		7505	PARK HE	IGHTS AVE	NUE, BA	ALTIMO	ORE, MD	21208	
تە تەر	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition		20b. P	lace of Dispos	sition (Name of	1	Date		cation - City or To	own. State	
+=	permit. Pages 1 and 2 Department of Health is Important: If item 27 is any Injury or other tra		1 KBurial 2 ☐ Cremation		State A	RETNGT	ONG.	ZUK					
Patient Baltimo	tmer tant jury		4 Donation 5 Dother (S	pecify)	A			09/2	0/2007	BAL	TIMORE,	MD	
調料	permit Depart Import any In		21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS.,										
	9 Q = # 9		Matt Levi 8900 REISTERSTOWN ROAD - PIKESVILLE, M										
			23a. Part1. Enter the disease, or	complications that ca	aused the death	n. Do not ente	er the mode of dyi	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between	
	Dhoolatan		Onset and Death									Onset and Death	
	Physician /Medical		immediate Cause (Final disease or condition resulting in death) The first resulting in death in the control of										
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o o	exe	Ä	resulting in death) Last Due to (or as a donsequence of):										
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Bo		1 -	23b. Was decedent pregnant in the past 12 months?	1 ☐Live bi	irth 2□Feta	Idéath 3□	Ectopic pregnanc	y		2	23d. Date of deliver Month	ery Day Year	
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#2	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					26. Place of Deat	h (Check only	one)			
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0	g Ph erth eral		27. Manner of Death	28a. Date o	of Injury	28b. Time of	28c. Inju Wo		28d. Describe		-		
o	Attending Ir death. ctor: After the funer	ţ	1 Matural 5 ☐ Pending 2 ☐ Accident investig	,	h, Day Year)	Injury		rk/]Yes 2 □ No					
2	deal deal ctor	ica Si	3 Suicide 6 Could n	ot be	of injury - At ho	me farm stre	eet, factory, office		28f Location	(Stroot and	d Number or Run	al Route Number,	
Division or Vital Records,	l or Attend after death Director: /	Certification:	4 ☐ Homicide determi	ned buildin	ng, etc. (Specify	y)	oot, ractory, onloc			own, State)		ar riodite Nambei,	
	urs a												
	Hospital Hospital Funeral tely filled	ca	(Check only 2 Medical I	g Physician: To the I Examiner: On the ba	isis of examina	wiedge, death tion and/or inv	n occurred at the to vestigation, in my	me, date and place, opinion, death occur	and due to the	e cause(s) e, date and	and manner as significant place, and due to	itated. to the cause(s)	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	one)	and mann	er stated.		7	, , , , , , , , , , , , , , , , , , , ,			,,		
-	To the Vithin 2 To the Complet	Σ	29b. Signature and title of certifier				29c. Licens	se number		29d. Date	e signed (Month,	Day, Year)	
			Dana Paun	MD			DEG	- 000		Sost	ember	16 2007	
	^		30. Name and address of person		of doath /lta-	23a) /Time !	Print\	- 600		T		2001	
	1,7				Sincu +		ol R.	ltimore					
			31. Date filed (Month, Day, Year)	7110	enistrar's Sinna	ture #	V 50	numore					
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	1- For State Registrar	Certificate of Death	Reg. No. 2007 3028
Physician	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Sentember 16, 2007 2. Date of Death Month 2. Day Year 2. Date of Death 2. Day 2. Date of Death 2. Day 2. Date of Death 2. Day 2. Date of Death 2. Day 2. Date of Death 2. Day 2. Date of Death 2. Day 2. Date of Death 2. Day 2. Date of Death 2. Day 2. Date of Death 2. Day 2. Date of Death 2. Day 2. Date of Death 2. Day 2.
Medical Examine	Marnice L. Brown 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	September 16, 2007 2326 hrs
	Union Hospital	Elkton	Cecil
Funeral		(In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Director	219-78-8269 1 M 2K F	Yrs. Months Days Hours Min.	May 26, 1967 Country)
	10a. State 10b. County 1	0c. City, Town or Location	10d. Inside City Limits
8	Maryland Baltimore	Rosedale	1 Yes 2 X No
aryland Sa-f show at once	10e. Street and Number 8762 Jarwood Road	10f. Zip Code	10g. Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once	8762 Jarwood Road	21237	USA
death with the Maryland or items 23a or 28a-f she must be notified at once	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	
death or ite	1 Yes 2X	ΧNo	Specify: Black
	Midowed 4 Divorced in res, Give real or Dates:	1 Yes 2 No specify: leted) 16a. Decedent's Usual Occupation (Give kind of w	
hour	15. Decedent's Education (Specify only highest grade comp	during most of working life. DO NOT use retired	
136 hin 72 e. than edical	Elementary/Secondary (0-12) College (1-4 or 54) O 17 Father's Name (First, Middle, 1 ast)	Never Employed	
21215-0036 21215-0036 Mental Hygiene. Marked other than 'c event, the Medical	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)
215 be file ntal H rked o	Michael Raymond Brown		Jean Tait
bould Med Med Miss ma	9 19a. Informant's Name/Relationship (Type, Print)		Rural Route Number, City or Town, State, Zip Code) Rosedale, Maryland 2123
nore, MD 2 gges I and 2 shou nt of Heakth and I t: If item 27 is r other traumatic	Marilyn Nesbit/ Mother 20a Method of Disposition	20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
Baltimore, permit. Pages I a Department of He Important: If ite Important: If ite Important or other tr	1 Burial 2 Cremation 3 Removal from State		·
	4 Donation 5 Other Specify:	Crownsville Vet. deme	4/07 tery Crownsville, Marylar
Balti permit. Departm Imports injury o	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ch	atman-Harris FuneralHome altimore, Md 21206
Physician	23a. Part I. Enter the disease, or complications that caused the	ne death. Do not enter the mode of dying, such as cardiac o	r respiratory arrest, shock, or heart Approximate Interval
Midical	failure. List only one cause on each line.	gastric perforation associated with Pica	Between Onset and Death
xaminer	or condition resulting in death) Due to (or as a consect		
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	if any, leading to immediate . Due to (or as a consect cause. Enter Underlying Cause	quence or):	4: - Balling
V - =	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consect cause) C. Due to (or as a consect cause)	quence of):	
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Box 687 death certifine the attending and for use as t	past 12 months? 1 Live birth 4 Pregnant at t 7 Yes 2 No 9 V Unknown		
Bo dea		but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
P.O.		1 Yes 2 ✔ No 3 Probably 4 Unknown	
ls, P quires t en sign uld be c	Wientan Netardation		24a. Was an 24b. Were autopsy findings available
cords, law requir has been s 2 should 1	<u>a</u>		autopsy prior to completion of cause of performed? death?
tal Rec	Mental Retardation Mental Retardation		1 Yes 2 No 1 Yes 2 No
ician:	(b) 25. Was case referred to medical examiner? Hospital:	26.Place of Death (Check at 2 ER/Outpatient 3 DOA Other Nursin	only one) ng Home 5 Residence 6 Other:
Division of Vital Records, rate death. The taw requires a ster death. The taw requires a flee the sterilicate has been significated the sterilicate has been significated the function, page 2 should be the function, page 2 should be the function of the function of the function.	27 Manner of Death 28a Date of Injur	The second secon	28d. Describe how injury occurred
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r Attend er death rrector:	Z Accident Investigation 28e. Place of Inju	ury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Divi	Suicide 6 Could not be determined (Specify)		or Town, State)
Hosp 24 ho Fune		knowledge, death occurred at the time, date and place, and	d due to the cause(s) and manner as stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	and manner stated.	nination and/or investigation, in my opinion, death occurred a	
	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Muld	O.C.M.E.	September 18, 2007
	30. Name and address of person who completed cause of de Ana Rubip MD. Assistant Medical Exam		1
10			
Sta	at 31. Date filed (Month, Day, Year) 22. Registrar	s digreenie	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Brown Donald 8:20 A M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ballimore N/A Harbor Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Secutiv Number 214 57 1299 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 x M 2 ☐ F -1299**Director** Oct 21, 1949 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 XYes 2 □No Director Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 3607 Fourth St. 21225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry USDA-US Gov't. Elementary/Secondary (0-12) 12 College (1-4or 5+) nd Mental Hygiene. marked other than Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill f Health and Mental Hitem 27 is marked oth other traumatic even Be Donald Calvin Brown, Sr. Marie Catherine Reinhardt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Sharon Lynn Brown 3607 Fourth St., Baltimore, Md. 21225 permit. Pages 1 and Department of Health Important: if item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md. 4 Donation 5 Dother (Specify) Cedar Hill Cemetery 9/21/07 21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., 238. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Pulmorary 3 hours disease or condition resulting in death) /Medical Due to (or as a consequence of): tertensive Crisis **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed ician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No for Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Atheroscheotic Cardiovascular Discove 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 certificate has Diabetes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner2-1 Ves 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Hospital or Attending 1 Anatural Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D41697

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

smeet

, Hanover

31. Date filed (Month, Day,

H.771, M.D.

R.

Baltimore, maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Physician** Month Dav Russell Boler Wardell September 05:28 AM 2007 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Baltimore VA Medical Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2 ☐ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1ÆYes 2□No Funeral Director MARVLAND 10e. Street and Number 10g. Citizen of What Country? ō or items 23a . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No à 3 K Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) KSETHLEHEM STEEL 12 TH GRADE ABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmonary **Physician** Discase Exacerbation /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No page director, 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:,
completely filled in by the f 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

neena.

29h. Signature and title of certifier

cause of death (Item 23a) (Type, Print)

29c. License number

Meena V. Shah

29d. Date signed (Month, Day, Year)

2007

September

21201

			State of Maryland / Dep. State Registrar State of Maryland / Dep.	artmer rtificat	nt of H	lealth a Death	and Me	ental Hy	/giene Reg. No	2007	302	283
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of D	eath		3 Time of	
	/Medic Examin	er	Peter Ellis Batt 4a. Facility Name (If not institution, give street and number) Suburban Hospital	September 16, 2007 19 4b. City, Town, or Location of Death Bethesda Montgomery					ath			
	Funeral Director		5. Social Security Number 6. Sex $1 \boxtimes M$ $2 \square F$ 7. Age (In yrs. last birthday) $101-48-1841$ $1 \boxtimes M$ $2 \square F$ 70 Yrs.		r 1 Year		Min.	8. Date of B (Month, D	irth lay, Year)	9. Bi	rthplace (State of country) tralia	r Foreign
	show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li						_		10d. Inside Ci	
	th the M or 28a-f e notifie	Direct	Maryland Montgomery Gaithersb 10e. Street and Number	urg 10f. Zip	o Code			***	10g. Cit	tizen of What C		X
	eath wi	eral	9709 Digging Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.		0886	ispanic Ori	igin? (Spec	ifu Voc or N		ralia 14. Race - Am	erican Indian	
336	72 hours after death with the Maryland ratural", or items 23a or 28a-f show dir a Examiner must be notified at	by Fun	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🔼 No	If Yes, spe		Specify:		cify Yes or N lican, etc.)	0-	Black, Wh	ite, etc.	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)		ork done o se retired	ation during mos d)	st of workin	g		(ind of Busines	s/Industry	
d 21	filed wil Hygien other th		17. Father's Name (First, Middle, Last)	itect	: 	18. Mothe	er's Name	(First, Middl			re/Const	ruction
vlan	buld be Mental arked o	To Be	Frederick Vernon Batt					Ellis				
Mar	nd 2 sh alth and 27 Is m r traum			_						or Town, State, Marylar	Zip Code) nd 20886	
nore,	ages 1 a ent of Hea t: If item y or othe		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, cre	osition (Na matory or	me of other plac	ce)		07 ^{ate} 21,	20c. L.	ocation - City o		
Baltir	permit. P Departme Importan any injur			2. Name ai	nd Addre	sa of Eacili	Funera	1 Home/	Rockv	ille, Inc		
	5 10 1		23a. Part1. Enter the direase, or complications that caused the death. Do not en shock, or heart brure. List only one cause on each line.							11.0	Approximat Interval Bet Onset and I	e ween
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	Examiner	_										
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.o9 ox 68	certifica ding ph se as th	/Medi	IF FEMALE: 23b Was decedent prognant 23c. If yes, outcome pf pregnancy	-						001 P-1 - / 1		
ان :e هر	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	Physician/Medical Examiner	in the past 12 months?	⊒Ectopic p ⊒ Other (s _i		/				23d. Date of d Month	,	Year
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م Vita	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		Oth			(Check only	one)			
Peter ion or V	ng Phys fter this ineral di	on: To	27. Manner of Death Natural 5 Pending 1 Inpatient 2 ER/Outpatient 28a. Date of Injury 28b. Time of Month, Day Year) Injury 1 Injury 2	28c. Injur Wor	4 L INC				6 □Other (Sp iry occurred	ecify)		
96 Division	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	M reet, factor		Yes 2□		8f. Location City or T	(Street a	nd Number or I e)	Rural Route Num	nber,
П	Hospital 24 hours a Funeral C	Medical Ce	29a. Certifler (Check only one) 29a. Medical Examiner: To the best of my knowledge, deal and manner stated.	th occurred	at the tin	me, date a	nd place, a ath occurre	nd due to the	e cause(s	s) and manner and place, and d	as stated. ue to the cause(s	3)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier			e number			29d. Da	ate signed (Mo	nth, Day, Year)	
			30. Name and address of person who completed cause of death (Item 23a) (Type		00	005	7/2	24		9117	107	.,
_	10		Truong Bao, M.D., 9715 Medical Center		#201	l, Ro	ckvil	le, Ma	aryla	and 208!	50	
-1	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 1 2007 32. Registrar's Signature									

ill Elizabeth Baker	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. State of Maryland / Department of Health and Mental Hygiene Certificate of Death
Physician/ Medical Examiner	Jill Elizabeth Baker September 9, 2007 Year 0220 hrs
	4a. Facility Name (if not institution, give street and number) Atlantic General Hospital 4b. City, Town, or Location of Death Worcester Worcester
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Months Days Hours Min. Sept. 10,1982 Mcs ground
and and and and and and and and and and	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
yland -f show once,	Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
ith the Maryland 23a or 28a-f sh- notified at once	10e. Street and Number 79 Mill Wheel Court 10f. Zip Code 21236 10g. Citizen of What Country? U.S.A.
after death w all", or items ner must be y Funer:	11. Marital Status 1
5 72 hours al Examir leted t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
5-0036 ed within 72 hour lygiene lygiene other than "natu he Medical Exan	Office Assistant Auto Dealership
21215-0036 uld be filed within 7 Mental Hygiene marked other than r event, the Medica	Lloyd Stanley Baker Connie Sue Tipton
MD 21 nd 2 should alth and Me nn 27 is ma aumatic ev	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lloyd Stanley Baker (Father) 405 Beechnut, Troy, Missouri 63379
4	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore, permit. Pages I at Department of He Important: If ite injury or other to	4 Donayon 5 Other Specify: Troy City Cemetery 9/15/07 Troy, MO
Ba perm Depa Impo injur	Kemper-Marsh-Millard Funeral Home 351 Monroe St., Troy, MO 63379
Physician /Medical xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death Death
<u>.</u>	Sequentially list conditions.
executed an and al-transit ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.
50, te be executed sysician and burial - transit	X UNPENDED #23a,27,,28a-f,perME,g872, 10/4/07 TT
ox 6876 sath certifica attending ph for use as the	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 1 ✓ Yes 2 No 9 Unknown Unknown
P.O. Bas that the degree by the edetached by the by Phy	
of Vital Records, P.C ng Physician: The law requires that ther this certificate has been signed meral director, page 2 should be det n: To Be Completed by	1 Yes 2 No 3 Probably 4 ✓ Unknown 24a. Was an autopsy performed? performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical 26.Place of Death (Check only one)
on of Vital Feding Physician: and. or: After this certifithe funeral director, trion: To Be C	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA Street House of Norsing Home 5 Residence 6 Other:
ion (trending death. After fur attion	1 Natural 5 Pending (Month, Day, Year) Fnd 9/9/2007 Fnd 1:42 am 1 Yes 2X No unk
Division o Hospital or Attending 24 hours after death. Funeral Director: After telly filled in by the funeral all Certification:	3 Suicide 6 X Could not be Homicide 6 X Could not be determined (Specify) other residence 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) other residence 28f. Location (Street and Number or Rural Route Number, City 206 N. Division St. Ocean City, MD
the Ho hin 24 h the Fur ppletely	1 Z9a, Certifier
To To con	
	30. Name and address of person who completed cause or death (Nam 23a)
	Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registra	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30285 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Burleson Day Year **Physician** W 0 >ar 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 411 Terrapin Grove Stevensville Queen Annes If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Dec 31, 9. Birthplace (State or Foreign Country)District Of Columbia Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 💢 F 1948 220-62-9268 58 Dec Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Directo Maryland Oueen Annes Stevensville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 411 Terrapin Grove 21666 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after comparation of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Example. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No Specify þ Specify: White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roy Wilson Belcher Stanbach Mary ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Jones, Daughter 245 Cross Creek Drive Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 09/21/07 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Consecutive Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryl Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COLUN Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sor sequence of): Examine burial-trar Due to (or as a consequence of): Physician/Medical as the asn Completed

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

death with the Maryland

Baltimore, Maryland 21215-0036

attending p Certification: To After this funeral d 24 hours at er deat Medical

Division or Vital Records, P.O. Box 687605

	d.			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	23	c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month D	y day Year
Part II. Other significant condition	ns cont	and an analysis declaration of the second se	olid tobacco use contribute to the ☐ Yes 2☐ No 3☐ Probal	
			utopsy prior to comperformed2 death?	sy findings available pletion of cause of
25. Was case referred to medical		26. Place of Death (Check on	nly one)	
examiner? 1 ☐ Yes No	H	pspital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	Residence 6 Other (Specify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident investig	ation	28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at Work? M 1 ☐ Yes 2 ☐ No	be how injury occurred	
3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locatio City or	on (Street and Number or Rural i Town, State)	Route Number,
		cian: To the best of my knowledge, death occurred at the time, date and place, and due to		

State Registrar

29d. Date signed (Month, Day, Year)

29c. License number

30. Name and address of rson who completed cause of death (Item 23a) (Type, Print)

and manner stated

900 Bestgate Road Suite 300 Annapolis, MD 21401 Holly Dushkin, M.D.

29b. Signature and Mg of certi

within 2. To the F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Marvel S. Baldwin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, July 2, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2XF 1916 Months Days Hours 91 218-01-0940 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show Examiner must be notified at Y☐Yes 2☐No N/A Baltimore Directo Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ō 21230 2105 Maisel Street **USA** items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 'natural', or Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo White þ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed wit Department of Heatth and Mental Hygiene Important: If Item 27 is marked other the any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edmond Smorgens Rachel Keerseilk ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2101 Maisel Street Baltimore, Maryland 21230 Sharon Decker, Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 remation 3 Removal from State Metro Crematory Inc. 09/24/07 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Conse MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ulmonavy Immediate Cause (Final hvonic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neum onia Sequentially list conumers, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 2 🗌 No 3 Probably 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? Yes 2 No 1⊟ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 은 27. Manner of Death 28a, Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? after death. Certification: Injury 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours a

To the Funeral I

completely filled

ald win, Marve

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

301

State Registrar

31. Date filed (Month, Day, Year)

163 32. Registrar's Signature

			1 - For Amend Items Registrar 23a Pt I	State of Ma 12,24a,25, I	.26,27,29g	rthicate of	Peath and N	,09/21/0	7dh 007	30287			
1	Physici	an	1. Decedent's Name (First, Middle, La	,				2. Date of Deat Month Septemb		3. Time of Death 7:45 AM M			
	/Medic Examin	al	Elizabeth L. Beh 4a. Facility Name (If not institution, giv			4b. City. Town. or	r Location of Death	septemb	4c. County of Deat				
	∈xamın	er	3145 Farnborough			Silver S			Montgome				
	Funeral Director		5. Social Security Number 6. 5 549-44-7922	8. Date of Birth (Month, Day, Mar 25,	Year) 9. Birth Co. 1931 Cal:	hplace (State or Foreign untry) ifornia							
	yland		Usual Residence of Decedent 10a. State 10b. County		10d. Inside City Limits								
	Be-f s	Director	MD Montgom	ery	Silver	Spring				1 Tyes 2 No			
with th	Dire	10e. Street and Number	h Course		10f. Zip Code	Spring	1	0g. Citizen of What Co USA	untry?				
	ns 23	Funeral	3145 Farnboroug	12. Was Decedent E	ver in U.S. 13.			ecify Yes or No-	14. Race - Ame	rican Indian,			
21215-0036	be filed within 72 hours after deeth with the Maryland ital Hygiene. Id other than "naturel", or items 23a or 28e-f show other than "naturel", or items 23a or 28e-f show event, I're Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Xes 2 Xes If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	Rican, etc.)	Black, White Specify: Wh				
ည်	72 ho	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	edent's Usual Occup	ation during most of work	ing	16b. Kind of Business/	Industry			
2	within and the state of the sta	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+) life.	DO NOT use retired	d) -		1				
N D	1	ပိ	17. Father's Name (First, Middle, Last	0	no	ousewife	18. Mother's Nam		OWN home Maiden Sumame)				
<u>a</u>		To Be	John Faustine N	lunes			Emma L	orraine	Teixeira				
ar∖	2 should be and Mental is marked raumatic ev	-	19a. Informant's Name/Relationship	Type, Print)	19b. Mail	ing Address (Street			City or Town, State, 2	Zip Code)			
Σ	and 2 saith a n 27 is		Kenneth Behannon	/spouse			W.		Spring, MI	20906			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta important: if item 27 is marked eny injury or other traumatic events.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Speci	y) 7		osition (Name of amatory or other plac	ca)	Date	20c. Location - City or	Town, State			
Balt	Departi Departi Import eny inj		21. Signature Service Licensee Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201										
п			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not er	nter the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death			
	Physician		Immediate Cause (Final disease or condition	Metestatic breast cancer 2 1/2 yrs									
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):									
		er	Sequentially list conditions, if any, leading to immediate	b. breast cancer 12 yrs Due to (o. as a consequence of).									
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c									
o,	e exec		resulting in death) Last	Due to (or as a	a consequence of):								
68760,	ificate be executed g physicien end as the burial-transit	edical		d									
_		/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of dea	livon.			
P.O. Box	The law requires that the death certiste has been signed by the ettending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown					Month Day Ye				
	res that the designed by the ellips detached for	þ	Part II. Other significant conditions congestive	-	-	underlying cause giv	en in Part I.		23e. Did tobacco use contribute to the cause of death?				
000	w require been si should b	eted							1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknow				
Division of Vital Records,	Physician: The law r this certificete has t ral director, page 2 s	Completed	Polywyalgia	Kneumatic	a			24a. Was a autops perform	y prior to death?	utopsy findings available completion of cause of			
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ō	Attending Physician: or death. ector: After this certifice by the funeral director, I	٦. ح	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Injur (Month, Day	nt 2 ER/Outpatie	of 28c. Injur	4 Indianing in		ence 6 Other (Spe	icity)			
<u>o</u>	uttending death. ctor: Afte	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) Injury		rk? Yes 2 □No						
Divis	al or Atte sefter des 1 Directo d in by th	Certification;	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place of Injury - At home, farm, street, factory, office 28f. Location					n (Street and Number or Rural Route Number, Town, State)				
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and/or i	ath occurred at the tir nvestigation, in my o	me, date and place, ppinion, death occur	and due to the c red at the time, d	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)			
	To the within To the comp	Me	29b. Signature and title of certifier	1		29c. Licens	e number	2	9d. Date signed (Mont	th, Day, Year)			
	,		find N	/ June	llmo	D3	D35996 9-13-07			13-07			
	6		30. Name and address of person who										
			Linda Marie Bu:	crell 2730	Universit	y Blvd St	e #400	Silver S	Spring,MD	20902			
	Sta Registi		SEP 2 1 2007	Maria A	ar's Signatur	9							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Anderson Wayne Berrett State of Maryland / Department of Health and Mental Hygiene 2007 30288 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month 1608 hrs **Medical Examiner** September 17, 2007 ANDERSON WAYNE BARRETT 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death University Hospital **Baltimore** 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Months Hours Director Country) Maryland 215-46-6778 60 1 XM 2 F June 19 1947 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b, County 28a-f show d at once. Yes 2 XNo Maryland | Harford Abingdon with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32<u>17 Wilson Ave</u> 21009 23a Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, Armed Forces? death White, etc. Never Married 2 X Married Yes 2 X No 9 Widowed If Yes. Give Year Yes 2x No specify: White within 72 hours after ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Appliance Sales & Elementary/Secondary (0-12) College (1-4 or 5+) marked other than MD 21215-0036 Repair Store 9 Owner/Operator 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file from the file of Health and Mental H fant: If item 27 is marked of or other traumatic event, the Be William Jesse Barrett Louise Haze1 Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary L. Barrett / Wife 3217 Wilson Ave., Abingdon, Maryland 21009 Baltimore, N perm t Pages I and Department of Healtl 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) Burial 2 Cremation 3 Removal from State fant: or off Hilltop Service Corp. 9-22-07 Towson, Maryland Donation 5 Other Specify nature of Funeral Service Licensee McComas Funeral Home, P.A. art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Maryland **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of):

and transit attending physician or use as the burial The law requires that the death certificate be Box 68760 o Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director;

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Sequentially list conditions,

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) UNPENDED AMENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Month Day past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 ✓ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✔ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) ursing Home 5 Residence 6 Others

	✓ Yes 2	2 No		Inpatient 2	ER/Outpatient 3	DOA Other'4 N
. Mai	nner of Death	1		28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?
	Natural	5	Pending	Sep 17, 2007	1419 hrs	1 Yes 2 ✔ No
V	Accident		Investigation			W 1 11 11 11 11 11 11 11 11 11 11 11 11
	Suicide	6	Could not be	28e. Place of Injury - At	nome, tarm, street, tacto	ery, office building, etc.
	Homicide		determined	(Specify) Major Roa	ad / Highway	

Due to (or as a consequence of)

28f. Location (Street and Number or Rural Route Number, City or Town, State Rt. 7 , Abingdon, (Specify) Major Road / Highway Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

O.C.M.E.

29b. Signature and title of certifier	
7 /	
10.1 -11 1 2 1	
	-
On Manager and address of name of the second and a death of the second	7

Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D.

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Most) State Registra

Nedical

29a. Certifier 1

28d. Describe how injury occurred Driver of motorcycle struck car

29d, Date signed (Month, Day, Year)

September 19, 2007

			1 - For State Registrar	State of Mary		irtment of F tificate of i		Mental Hy	giené Reg. No		30289
			Decedent's Name (First, Middle, Last)					2. Date of D	eath		3. Time of Death
	Physici /Medio		HARRY JOSEPH E	RADY SR.				Month SEPTEM	Day BER		23:27 M
	Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or	r Location of Death			County of Death	
			Harford Memorial	Hospital		Havre d	le Grace		Ha	arford	
	Funeral		5. Social Security Number 6. Sex	7. Age (In M 2 ☐ F	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth lay, Year)	9. Birthi Cou	place (State or Foreign ntry)
	Director		086-22-9257	M 2 1	76 Yrs.			May 8,	193		York
	land		Usual Residence of Decedent 10a, State 10b, County	100	c. City, Town or Lo	cation					10d. Inside City Limits
	Mary f sh	ŏ	M		ا المسال على المسال	7 _					1 ☐ Yes 2 ☐ X No
	28a	rec	Maryland Harford 10e. Street and Number		Churchvi I	10f. Zip Code			10g. Cit	izen ol What Cou	ntry?
	3a o	<u>=</u>	1207 Mystic Court			21028			USA		
	death with the Maryland ime 23a or 28a-f show r must be notified at	Funeral Directo		2. Was Decedent Ever	in U.S. 13. \	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S	pecify Yes or N		14. Race - Ameri	
5-0036	in 72 hours after death with the Marylan "natural", or Iteme 23a or 28a-f show ledical Examinar must be notified at	þ	1 ☐ Never Married 2 ☆ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ⊕Yes 2 □ No If Yes, Give Year or Dates:		Yes 2 No	Specify:	o rsican, etc.)		Black, White, Specify: Wh	etc. ite
Ž	72 ho	Completed	15. Decedent's Educ		16a. Deced	lent's Usual Occup	ation	4	16b. K	ind of Business/In	
7	within 7 ene. than "r	npie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	d) most or wor	King			
7		Co		2	Polic	ce Office				Enforce	ment
	e d a b	Be	17. Father's Name (First, Middle, Last)	_			18. Mother's Nan			Surname)	
<u> </u>	should ind Men in marke umatic	ဥ		ady			Elsie G				
Maryland	th and the number of the numbe	8	19a. Informant's Name/Relationship (Typ. Harry J. Brady Jr.			g Address (Street)					o Code)
o,	Hea Hea ther	1	20a. Method of Disposition	·	Ob. Place of Dispo			Date		ocation - City or To	own. State
Baltimore,	m O .		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	movar from State			1	0-07			
	permit. Page Depurtment Important: If any injury or once.	1 3	4 □Donation 5 □ Other (Specify) 21. Signature of Juner Pervice Ligense		Harford N					rdeen,Ma	ryrand
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			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ation that caused the	death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory	guoii, arrest,	, raryra	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	< 1	+ OLAIC						Onset and Death
	/Medical		resulting in death)	Due to (or as a cor	rsequence of):						3 7493
	Examiner		Sequentially list conditions, b.	Peris	tonitis						3 Pags
4	ν =	iner	if any, leading to intriediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	ισογμοτικο υΙ).	1/1	0 0	p. 0			
	ecute and trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Sayl		r with 1	ertorat	ion			3 Days
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94/60	physi the	dical	d.							-	
X	eath certifi attending for use as		IF FEMALE: 23	c. If yes, outcome of pr	egnancy					23d. Date of deliv	00/
ň	Jeath a atter d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)				Month	Day Year
j.	that the deed by the	hysi	9 Unknown	9□ Unknown							
ري ح	w requires that the been signed by th should be detache	by P	Part II. Other significant conditions conf	A	t resulting in the ur	derlying cause give	en in Part I.	23e. Did	tobacco u	use contribute to t	he cause of death?
coras,	en sig	edi	Acute Kenal to	ilure, Ac	ute Hepa	tic tail	ure	1 🗆	Yes 2	□No 3□Prot	bably 4 Unknown
္မ	≥ □ ਯ	Completed	Acute Myocas	- dial Infa	ration			24a. Wa	s an opsy	24b. Were auto	opsy lindings available
Ľ	The It	mo:						perf	ormed? 2 No	death?	
<u>E</u>	vician: The lav certificate has rector, page 2	Be	25. Was case referred to medical examiner?				26. Place of Dea				
5	hysic his co	2	1 XYes 2 No		2 ER/Outpatien		4 Nursing H	ome 5□Res	sidence	6 ☐Other (Special	fy)
	Attending Physician: r death. sctor: After this certific by the funeral director,	ë.	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injun World		28d. Describe	how injur	y occurred	
S	Nttendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	200 Place of leiver	At home larm of		Yes 2 □No	28f Location	(Ctroat a r	d Number of Dur	1 Do to Market
DIVISION	or A after Direct in by	Certification:	4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S)		eet, ractory, office			own, State	d Number or Rura)	ai Houle Number,
	Hospitel or Atten 24 hours after deat Funeral Director: stely filled in by the		29a. Certifier 12 Certifying Phys	inlan: To the best of my	knowledge death	programed at the time	na idate and class	and due to the	i douseful	and manner as a	tated
	24 h 24 h Fur letely	Medicai	(Check only 2 Medical Examin	er: On the basis of examination and manner stated.	mination and/or inv	estigation, in my o	pinion, death occu	rred at the time	, date and	place, and due to	o the cause(s)
	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier			29c. Licensi	e number		29d. Dat	te signed (Month,	Day, Year)
)	~		Marco Samo	IL.		D4	0819		Sen	Lomber	17,2007
1	1+1		30. Name and address of proof who cor	npleted cause of death	(Item 23a) (Type,				-ch	Contract	1,000
٢	1 1	1		rora, mo	501 U	nion St	Harre	De Grac	2	21078	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	in the					
	Registr	ar	SEP 2 1 2	007 person	1 15. 19	The state of the s					

Harry Joseph Brad

07-06577 Darnell I. Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 30290

2111011 12 210 1111		For State	Certificate of	f Death		Reg. N	No	01 0023
Physiciar		Decedent's Name (First, Middle,Last)				Date of Death Month Da	y Year	3. Time of Death
al Examin		Darnell Isaac Brown				August 25, 20	007	0336 hrs
	4	 Facility Name (if not institution, give street and number) 	l l		Location of Death		4c. County of Deatl	
		Pennsylvania Avenue & Forrestville Road		Forrestville			Prince George	
Funeral	1	. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Yea		_	M/DD/YYYY) 9. Bii Forei	thplace (State or
Director		579-94-7295 1XM 2 F 33	Yrs	Months Day	s · Hours Min.	7/25/19	74 Wa	shington, DC
		Isual Residence of Decedent						10d. Inside City Limits
, any		0a. State 10b. County	10c. City, Town or Local					1 X Yes 2 No
and show	۱,		Washington					
Aaryland 28a-f show 1 at once.	ωl	0e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	intry?
the N a or i	5	607 Galveston Place, SE		20032			nited Star	tes
with ms 23	ᅙ	1. Marital Status 12. Was Deceden		as Decedent of His	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-	14. Race - Ame White, etc.	rican Indian, Black,
Jeath r iten	Funeral		X No			1 10011, 010.7		,
after o	Š-	Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2X No			Specify: Bla	
5-0036 led within 72 hoursal Hygient natural other than "natural the Medical Examin		15. Decedent's Education (Specify only highest grade co	mpleted) 16a. Deceder	nt's Usual Occupa	ation (Give kind of version). DO NOT use reti		b. Kind of Business	/Industry
72 h	Completed	Elementary/Secondary (0-12) College (1-4 or	5+)				Iool + b - om	
036 rithin 72 ene. er than Medical	티	12	Certii	ted Phys	sical The	(First, Middle, Mai	Healthcar	=
215-0036 be filed within 7 atal Hygiene. rked other than ent, the Medica	ပိြ	17. Father's Name (First, Middle, Last) Isaac Brown, Jr.				tte E. Co		
2121 uld be fill Mental F marked	å		105 Mailie	a Addross (Stro			r, City or Town, Stat	te, Zip Code) :
Imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene lant: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examilner must be notified at once or other traumatic	٤	19a. Informant's Name/Relationship (Type, Print) Bernadette E. Brown/ Mothe						lle,MD 20782
MD nd 2 sho alth and alth and rm 27 is	-	20a, Method of Disposition	20b. Place of Dispo				Oc. Location - City of	
or He	-	1 XBurial 2 Cremation 3 Removal from S	tate crematory or o	ther place)				
Page nent ant:		4 Donation 5 Other Specify:	Mt. Olive			31/200/[Vashington	n, DC
Baltimore, MD 2: permit. Pages I and 2 should Department of Health and M Important: If item 27 is minjury or other traumatice		21. Signature of Funeral Service Licensee		Name and Addres		Was	shington,	DC 20020
		Larry & Semmons 23a. Part I. Enter the disease, or complications that cause		pe Funer	cal Home,	261/ Pei	nnsylvania	Ave, SE Approximate Interval
Physician		failure. List only one cause on each line.		the mode or dying	g, such as cardiae	or reopridicity amount	, 5,755,75	Between Onset and Death
Medicai xaminer		Immediate Cause (Final disease a Multiple Injurie						
		or condition resulting in death) Due to (or as a con	sequence of):					
	ا پر	Sequentially list conditions, if any, leading to immediate Due to (or as a con	sequence of):					
	١	cause. Enter Underlying Cause (Disease or injury that initiated						
V- 5	Examine	events resulting in death) Last Due to (or as a con	sequence of):					
Division of Vital Records, P.O. Box 68760, "To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		d.			••			
o, o, e be exi	Medical	UNPENDED						
76C icate phys		at the bar to the same and to the	ome of pregnancy	Total dooth 3	Ectopic pregr	iancy	23d. Date of delive Month	ery Day Year
Sox 687 leath certific e attending for use as the	sician/	nast 12 months?	at time of death	Fetal death 3 Other (Specify)	Lotopio progr	idiloy		
Box 68760, e death certificate be the attending physic ed for use as the bur	Ş	1 Yes 2 No 9 Unknown g Unknown	<u> </u>	Strict (Speeding)				
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Division of Vital Records, tal or Attending Physician: The law requir is after death. **I Director: After this certificate has been siled in by the funeral director, page 2 should	etec					24a. Was ar autopsy		autopsy findings available o completion of cause of
COr law r has b	ď					perform	ned? death	?
tal Rection: The certificate	S			26 DIa	ce of Death (Chec	1 Y Yes 2	No 1	162 2 140
cian:	Be	25. Was case referred to medical examiner?	tient 2 ER/Outpatie		Louis		esidence 6 🗸 Ot	her: Scene
Physical directions	٩	1 Yes 2 No 1 Inpa 27. Manner of Death 28a. Date of I			njury at Work?		ow injury occurred	
n of ding Pl	on:	1 Natural 5 Pending Aug 25, 20			Yes 2 ✔ No	Driver auto fi	xed object collis	sion
Siol Nttendeath death ctor:	cati	2 A seidest Investigation	Injury - At home, farm, st	reet factory office	e building, etc.	28f. Location (St	reet and Number or	Rural Route Number, City
ivis	Certification:	3 Suicide Could not be			o b an an ig , e i e i	or Town Sta	ate)	rille Road, Forrestville, M
Division of Vital Rec To the Hospital or Attending Physician: The l within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page		4 Homicide	fajor Road / Highwa		data and place, at		A	
n 24 n 24 ne Fu	cal	(Check only	my knowledge, death occ xamination and/or investig	gation, in my opini	ion, death occurred	at the time, date a	nd place, and due to	the cause(s)
To the within the comp	Medical	29b. Signature and title of certifier	d		ense number		29d. Date signed (
	2	29D. Signature and une of certifier	1		C.M.E.		August 25, 200	_
		TIC WY	/				,,	
		30. Name and address of person who completed cause of Susan Hogan MD. Assistant Medical		enn Street Re	altimore, MD 2	21201		
		<u> </u>		Jan Outer, Da				<u> </u>
St Regis	ate	000 - 4 2007 8	rar's Signature	GORNES				

			For State Registrar	State of Mar		artment of H rtificate of I			jiene leg. No. 200	7 30291
Þ.	Physicia		1. Decedent's Name (First, Middle, Las		Curtis E	3ream		2. Date of Dea Month	th Day Year	3. Time of Death
	/Medio	200	4a. Facilify Name (If not institution, give	street and number)		4b. City, Town, or	r Location of Death		dc. County of Dea	
		Ŭ.	3103 Cornwall :	Road		Dı	unda1k		Baltin	more Co.
	Funeral Director		5. Social Security Number 6. Security 171–24–5386	7. Age ((In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March	, Year) C	rthplace (State or Foreign ountry) ennsylvania
	pu »		Usual Residence of Decedent 10a, State 10b, County	1	10c. City, Town or Lo	ecation				10d. Inside City Limits
	//anyla f sho ed at	o			,,			D 3 - 11		1 □Yes 2 🔀 No
	the N 28a-	Director	Maryland Baltin	nore		10f. Zip Code		Dunda11	<u><</u> I 0g. Citizen of What C	ountry?
	h with 23a ol st be		3103 Cornwall	Road :			21222		United St	tates
0	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 □ Never Married 2☑ Married	12. Was Decedent Even Armed Forces?		Was Decedent of H		pecify Yes or No- pecify Yes or No- pecify Yes or No-		
<u> </u>	hours a tural", c	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No dent's Usual Occup	Specify:		Specify: 16b. Kind of Business	White
21215-0036	thin 72 e. an "nal Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done of NOT use retired	during most of world)	king	Tob. Nata of Business	s/moustry
7	filed wil Hygien other th ent, the	Con	12 years		To	olmaker	40. Mathemate Name	- Contract	A T & T	
Maryland	8 - a e	Be	17. Father's Name (First, Middle, Last) Forrest Isiah B:	ream					Maiden Surname) Ensberger	
$\frac{8}{2}$	should Ind Men s marke umatic	2	19a. Informant's Name/Relationship (7		19b. Maili	na Address (Street			r, City or Town, State,	Zip Code)
	and 2 s ealth ar n 27 Is ner trau		Mrs. Lillie T. B			3 Cornwa			, Maryland	21222
Ä,	~ T % =		20a. Method of Disposition	Dames of frame Chair	20b. Place of Dispo	osition (Name of matory or other place	ce)	Date	20c. Location - City o	r Town, State
Ē	Pages ment of l ant: If its ury or o		12 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		-	Valley Me	1			ium, MD
Baltimore,	permit. Pages: Department of I Important: If Ite any Injury or of		21. Signature of Funeral Service Lices	300 CO	0 2	2. Name and Addre Duda-Rucl	ss of Facility k Funeral	Home of	Dundalk, Maryland 21	Inc. 222
h	7-3	J	23a. Part1 Enter the disease, or comp shock, or heart failure. List only	lications that caused th	ne death. Do not en					Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	a. Male	yout /	helm				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as x	c nsequence of):					
	ât.	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):					
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8760,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last	Due to (or as a o	consequence of):					
9	tificate ng phy: as the	Medic		u						
). Box	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1□Live birth 2 4□Pregnant at tir 9□Unknown	☐ Fetal death 3 [⊒Ectopic pregnancy ⊒ Other (specify)	у		23d. Date of de Month	elivery Day Year
P.0	that the	, Phy	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	w requires that the de been signed by the s should be detached	ed by						1 🗆 Y	es 2 X No 3□F	Probably 4 □Unknown
Records,	ne faw re has bee ge 2 sho	Completed		_				24a. Was a	an 24b. Were a	autopsy findings available completion of cause of
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ō	Phys r this ral dir	: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time o	of 28c. Injur	vat		ence 6 Other (Sp ow injury occurred	ecify)
on	nding th. r: Afte e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day \	Year) Injury	M 1 🗆	fk? Yes 2 ∐ No		• •	
Division or	or Atte after des Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
)	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.		29a. Certifier (Check only one) (Check only one)	ysician: To the best of niner: On the basis of e	examination and/or in	th occurred at the tin	me, date and place	, and due to the our rred at the time, o	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	o the vithin 2 o the omple	Medical	29b. Signature and title of certifier	and manner state	/	29c. Licens			29d. Date signed (Mor	
	⊢ ≶ ⊨ ŏ		Wa Ca	latatul	m	1	24356		September.	17 2007
,	n)		.30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type,	Print)	~			17, 2007 OFE, MD21837
			William C. Wate	1-16/0 91C	's Signature	lin Squa	ce Driv	e Stedde	20 Baltinu	ore, MD21237
	Sta Registr		31. Date filed (Month, Day, Year) 5EP 2 1 2007	32. Hegistrar	s Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh 9871 9-28-07 vt.
State of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 0 7 30292 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2007 Sept. 20, 1:25 AM F. Ballinger Evelvn 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Stella Maris Hospice Timonium Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country)
New Jersey Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth Days 3/14/11919 88 401-2366 1 □ M 2X F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Baltimore Timonium 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 Fallsbrook Rd. 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married White 1 □ Yes 2 🛛 No Specify. Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
Secretary Elementary/Secondary (0-12) College (1-4or 5+) Contracting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Pilarim Hazel Friant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Gilbert Ballinger / Husband 203 Fallsbrook Rd. Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place)
Moreland Mem. Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/24/2007 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Signature Kimberly Davidson 22. Name and Address of Facility 5305 Harford Rd. Baltimore, MD 21214 Leonard J. Ruck, Inc. enviol 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Unleaded or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 🗶 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Records, P.O. Box 68760. EVELYN BALLINGER Division or Vital

attending physician and for use as the burial-tran signed l this certificate After within 24 hours after death.

To the Funeral Director: Aft

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show almoprant: If Item 27 is marked other than "natural", or items 23a or 28a-f show important: If Item 27 is marked other than any injury or other traumatic event, the Medica Examiner must be notified at once.

Physician

/Medical

Examiner

Examiner

by Physician/Medical

Completed

Be

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Certification:

Medical

29b. Signature and title of certifier

DR. TARIQ MAHMOOD

SEP 2 1 2007

with the Maryland

a.m

20,

21215-0036

Maryland

Baltimore, SEPTEMBER

> State Registrar

DHMH 17 Rev 1/2001

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

SEP 2 1 2007

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	•	1- For Registrar Amend #18, perFH, C871, 9/28/07 TT Cell	rtificate of Death		Reg. No. 2007 3029	J [
Dharatai		1. Decedent's Name (First, Middle, Last)		2. Date of De	ath 3. Time of Dea	,th
Physici /Medio		Norma Jean Bathory		Sept.	14 2007 11:08 p	M
Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		Stella Maris Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Timonium If Under 1 Year If Under 24 Hrs.	8. Date of Bird (Month, Da	Baltimore th 9. Birthplace (State or Fo	reiar
Funeral Director		218-26-1201 1 M 2 XF 77 Yrs. Usual Residence of Decedent	Months Days Hours Min.	(Month, Da 09/16/		
yland now at		10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Li	
a-f sh	ctor	Maryland Baltimore Edgemere	<u> </u>		1 □ Yes 2 2	No
ith the	Dire	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?	
s 23a	ral	3116 Sparrows Point Road 11 Marital Status 12. Was Decedent Ever in U.S. 13.	21219		United States 14. Race - American Indian,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparatment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (S _I If Yes, specify Cuban, Mexican, Puert 1 □ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, etc.	
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in 72 in 72 "na" r	plete	(Specify only highest grade completed) (Give	kind of work done during most of wor DO NOT use retired)	king	Too. Talle of Deciriosci madely	
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al Hyg I othe	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle,	Maiden Surname) Dexter	
Menta Menta arked atic e	2	Chester Gilbert Brown, Sr.	Josephin		Daxter	_
2 short and is m		, , , , , , , , , , , , , , , , , , , ,	ng Address (Street and Number or Ru			
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artme artme ortani Injury		or other different formation of the 1 2	Mem. Gardens 9/19, 2. Name and Address of Facility		Bel Air, Maryland	
Depi Impo any	5 5	116 1188 20181	Ouda-Ruck Funeral			
	į.	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory a	rrest, Approximate Interval Betwee	n
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The law requires that the death certificate te has been signed by the attending physage 2 should be detached for use as the	Physician/Medic		Other (specify)		Month Day Yea	
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Attending Physician: r death. ector: After this certifica by the funeral director.	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	nt 3 DOA Other: 4 Nursing H	lome 5 ☐ Resi	idence 6 X Other (Specify) HOSPIC	E
ding Ph		27. Manner of Death 1 Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe	how injury occurred	
tendlleath.	cati	2 Accident investigation	M 1 Yes 2 No	096 Logation (Street and Number or Rural Route Number	
or All	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office		wn, State)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1X Certifying Physician: To the best of my knowledge, deat	th occurred at the time, date and place	, and due to the	cause(s) and manner as stated.	
ie Hoor 24 h	Medical	(Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occi	urred at the time	, date and place, and due to the cause(s)	
To th To th	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)	
7		/ "-	24372	1	9/17/07	
10		30. Name and address of person who completed cause of death (Item 23a) (Type,				
		DR. TARIQ MAHMOOD 2300 DULANEY VALL 31. Date filed (Month, Day, Year) 32. Registrar's Signature	EY RD. TIMONIUM,	MD 210	93	
St Regist	ate rar	2007 Read A Margaret	4			
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State of Maryland / Department of Health and Mental Hygiene 30295 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Solomon Baylor 12:25 p Sep 15, 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Oak Crest Village If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□**y**M 2□ F Months I Hours Director Virginia Apr 25, 1922 213-14-9834 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County show iges 1 and 2 should be filed within 72 hours after death with the Maryla nt of Health and Mental Hygiene.

If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐XYes 2 ☐ No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 8800 Walther Boulevard Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1943 1 ☐ Yes 2 ☐ ★lo Completed by Specify. Black 3 Widowed 4 Divorced 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Circuit Court Judge land 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Carter John Baylor Pages 1 and 2 should ပ Maryl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Walther Boulevard-Apt 1120 Baltimore, Maryland 21234 Ernestine Baylor Wife timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or or 1 □ Suria! 2 □ Cremation 3 □ Removal from State 09/20/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 22. Name and Address of Facility of Funeral Service Licen Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death art1. Enter the disease, or om flications that caused the dark h. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician menho /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit Due to (or as a consequence of): Physician/Medical attending pt 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a o. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 No certificate of the Hospins, within 24 hours after death.

If the Funeral Director: After this certificate for the Funeral Director: After this director, ps. 1. The funeral director, ps. 1. The funeral director, ps. 1. The funeral director, ps. 1. The funeral director, ps. 1. The funeral director, ps. 1. The funeral director, ps. 1. The funeral director, ps. 1. The funeral director, ps. 1. The funeral director of the funera 1∐ Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 🗌 Yes Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဠ 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ō 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Sion (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. within 7 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walther Blud, Parkville 31. Date filed (Month, Day, Year) Registrar's Signature State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 22 per fh 8871 9-21-07 vt. State of Maryland Abepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 430 PM **Physician** Madelyn Cooke Velun 9 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner + Miltord Mill Koa d Windson Mil Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days 1 □ M 2 💢 F 217.20.455 80 Yrs. Director 10/06/192 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Baltimore 1 ☐ Yes 2 No Willasor Mill MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number - Milford USA Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black ۵ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Paralegal 17th ora de.

17. Father's Wame (First, Middle, Last) 2 years 18. Mother's Name (First, Middle, Maiden Surname) Blanche Walker Norman Barnes 9 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madeline Brooks Mill Road Windsor Mill, MD 21244 Cousin Miltord 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State Baltimore, MD Greenmount Crematory 09/24/07 22. Name and Address Facility Companion Funeral Sewices 4 119-121 S. Stricker St. Balto. Md. 21223 21. Sign ture of Funeral Service Licensee

22. Name and Address Facility Omposition

119-121 S. Stricker St. B

23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician pancreatic 6 months comcex /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the sahould be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No cate has I 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 5 ☐ Pending investigation 1. Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brancer June 31. Date filed (Month, Day, Year) 32. Paistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 29c per dwr 8871 9-21-07 vt
State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Johnathan Michael Clevenger 831 PM 09 67 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death University of Maryland altimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. 28 1 √ M 2 □ F Sept 17 2007 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Carrol1 Sykesville 1 ☐ Yes 2 📉 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA 1508 Buckhorn Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼No If Yes, Give X If Yes, Give 7 Year or Dates: 1 ☐ Yes 2 🗓 No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) never worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Todd Michael Clevenger Julie Ann Teal 19a. Informant's Name/Relationship (Type. Print)
Todd M. Clevenger (father) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1508 Buckhorn Rd., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 □ Cremation 3 □ Removal from State Granite Missionary Cem9-22-07 Woodstock, MD 4 ☐ Donation 5 ☐ Other (Specify) P.O. Box 195 Sykesville, MD 21784 21. Signature of Funeral Service Licensee Paige Harght Herisert 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sacrococcygeal Kuptured Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ninpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month. Dav. Year) P19717

Examiner law requires that the death certificate be executed Box 68760, P.0. Division or Vital Records, or Attending Physician: To the Hospital

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Physician/Medical

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Completed

Be

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Certification:

Medical

State

31. Date filed (Month, Day,

Funeral

Director

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permit. Pages 1 and 2 s
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Important: If Item 27 Is
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Physician

/Medical

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been signed by the should be detached

page 2 s

After this certificate

within 24 hours after used.....

To the Funeral Director: After the Funeral Director of the fur

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 1/2001

ORIGINAL

St. Boltmore MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

32. Recistrar's Signature

2007

State of Maryland / Department of Health and Mental Hygiene Son Ye Callahan 2007 30298 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle.Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year September 17, 2007 1219 hrs Medical Examiner Son Ye Callahan c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Laurel 258 Ironshire South If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Hours Min Director Country) 1947 219-68-6067 1 M 2X F 60 Feb. 16. Korea Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b County Yes 2XXNo 23a or 28a-f show must be notified at once Anne Arundel Laurel Director 10g. Citizen of What Country 10e. Street and Numbe 10f. Zip Code 258 Ironshire S. 20724 USA Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.), Armed Forces? White, etc. 1 Never Married 2XX Married 2 X No Yes If Yes. Give Year Yes 2 X No specify: Specify: Asian 3 Widowed Divorced "natural" þ 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Pages I and 2 should be filted within 72 Factor of Health and Mental Hygiene, ant: If item 27 is marked other than "r or other traumatic event, the Medical E 21215-0036 Beautician Beauty Salon 10th 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Choi Sang Jin Chun Yang Ae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) timore, MD Floyd M. Callahan/Husband Ironshire S. Laurel, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 XXCremation 3 Removal from State Department of Important: 1 9/20/2007 Odenton, MD West Arundel Crem. Donation 5 Other Specify: 22. Name and Address of Facility 21 Signature of Funeral Service Licensee Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD M01103 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician Between Onset and failure. List only one cause on each line /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED attending physician or use as the burial .27.perME,g872, 10/2/07 TI Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) detached for Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ó ģ ď 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy s certificate has rector, page 2 sh has death? performed? Yes 2 No 1 1 Yes No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other₄ DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient ER/Outpatient 3 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural Yes 2 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 18, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 gistrar's Signature

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 17, 2007 8:35P THOMAS FRANCIS CADWALADER 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) N/A Baltimore Joseph Richey If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | November 18,1912 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) 5. Social Security Number Months 2 🗆 F ¹\\\X\\\ Maryland 218-07-2284 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County XXYes 2□No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21210 USA 733 Colorado Avenue 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 □ No 41 - 45 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes X2X No White Specify. 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Life Insurance Insurance Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth M Read Thomas Francis Cadwalader 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
733 Colorado Avenue Baltimore, Maryland 21210 19a. Informant's Name/Relationship (Type. Print) Phyllis J Cadwalader Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Green Mount Crematory Sep. 25,2007 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home John O. Mitchell 6500 York Road Baltimore, Maryland 21212 23a. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Prostate (aner your Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed' 2 3 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show appriant: If item 27 is marked other than "natural", or items 23a or 28a-f show appring items 20 or other traumatic event, the Medical Examiner must be notitified at once.

Baltimore, Maryland 21215-0036

physician and the burial-transit ed by the a detached f is certificate has been signed director, page 2 should be det funeral To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur

Division or Vital Records, P.O. Box 68760,

Be Completed by

State Registrar

Medical

29a. Certifier (Check only one)

Physician/Medical Examiner Certification: To

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural

29b. Signature and title of certifier

5 Pending investigation 2 Accident 3 ☐ Suicide 4 ☐ Homicide

6 ☐ Could not be determined

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Eather (Specify) | Selection | 28a. Date of Injury (Month, Day Year)

and manner stated.

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21204

MD

29c. License number

1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 09.18.2007

वार्य में तासान

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAYMOND W. WILSON MD. 6565 N CHARLES ST, SLITE 416, BALTIMORE

31. Date filed (Month, Day, Year) 2007 21

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:00 AM Mercedes Betty Lee Cox 2007 Sept 16 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ba 8. Sate of Birth (Month, Day, Year) Bultimore 12. timore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 5. Social Security Number Sex **Funeral** Min. Months Days Hours 1 ☐ M 2 🕱 F 1936 Maryland 212-34-5320 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show 1 ☐ Yes 2 XNo Director Bel Air Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or 21015 USA 1310 S. Tollgate Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married "natural", or 1 ☐ Yes 2 💆 No Specify. Baltimore, Maryland 21215-0036 ģ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Health Care d 2 should be filed w h and Mental Hygiei 7 Is marked other tt permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: If item 27 Is marked other th
any injury or other traumatic event, the
once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John (nmn) Zadarogny Mercedes (unk) Love ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1310 S. Tollgate Rd., Bel Air, MD 21015 Richard Cox Sr. / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland Bel Air Memorial 9-21-07 21. Sign wife of uneral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or combication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onect and Death Immediate Cause (Final **Physician** ncarcerates disease or condition resulting in death) /Medical Due to (or as a consequence of): ML Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 28 No 1□ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No npatient 🏠 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year, Injury 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident atter death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled

State

Registrar

PhiD MD

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10NG 240

31. Date filed (Month, Day, Year) SEP21

(Check only one)

29b. Signature and title of certifier

W. Beliedere Balling 18, MD 202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM! 7.8 per FH C872 10/5/07 WS
State of Maryland 7 Department of Health and Mental Hygien 9 0 0 7 3030 l Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sept. **Physician** Year Vero 2007 /Medical Hnn 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner COH Howard Date of Birth 1941 (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F Months Days Min Yrs. Director 62 rountain Green MO Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f sh mary injury or other traumatic event, the Medical Examiner must be notified a once. 1 ☐ Yes 2 No Director Howar COTT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 Completed by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Joseph 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ e 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellicott City Vera MD UPL Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - dity or Town, State 1 ☐ Burial 2 X Cremation 3 ☐Removal from State Evans Funeral Crapel-Boll Forest Hill, MP 4 ☐ Donation 5 ☐ Other (Specify) 07 Jork Rd. Timonium MD 21093 21. Signature of Funeral Service Licensee Peacoful Alternatives Funera NOTA 23a. Part1. Enter the dise shock, or heart failur ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, b. List only one cause on each line. Approximat Interval Between Onset and Death Immediate Cause (Full Physician disease or condition resulting in death) 3 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Medical Certification: To Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): or Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year Day 5 Other (specify) cate has been signed by the a page 2 should be detached 1 ☐ Yes 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 1 Yes 2 funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation M 1 Yes 2 No 2 Accident within 24 hours after death To the uneral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed car 1065 31. Date filed (Month, Day, 32. Registrar's Signature Year) State 2007 1 Registrar SFP

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Month **Physician** Rosalie Dolores Dabrowka September 18 2007 1:55 P. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore N/A 4011 - 4th Street 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Days 1 ☐ M 2 😾 F 93 215 01 0825 June 2, 1914 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rai", or Items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No N/A Baltimore Maryland | Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21225 4011 - 4th Street Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race · American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 Specify þ 3 Nidowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Employee M.V.A. Fiscal Clerk Department of Health and Mental Hygis Important: If item 27 is marked other is any injury or other traumatic event, tt once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Noto Mary M. Kapraun ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Monroe / Daughter 4011 - 4th Street Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 9/22/2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. Communication (4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY YEARS **Physician** /Medical Due to (or as a consequer ce of): HEROSCLEROTIC CARSIOVASCULAR SISEASE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctonic pregnancy Month in the past 12 months? Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Yes 2 | 1 | Yes Medical Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? Year) 1 Natural (Month, Day 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 1406 S. CRAIN HWY CARLOS SUITE 106 M.D .2168 31. Date filed (Month, Day, 32. Registrar's Signature State SFP 2 2007 1 Registrar

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Sequentially list conditions: Part Lead of the past 12 months? 23d Date of delivery			resulting in death)		-												
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25. Was case referred to medical examiner?	ord O	aen si											1 [] Yes	2X No	3 Pro	bably 4 Unknown
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					07	32. Registr	ar's Signa	-0	9								

State of Maryland / Department of Health and Mental Hygien 200730304 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 2:30 AM ^M Frieda A. Dietz 09 19 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Brightview Assisted Living

6. Sex 7. Age (In yrs. last birthday) Bel Air, Maryland Harford Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 X F Days Hours Director Yrs 216-30-6511 89 01/15/1918 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? in than "naturel", or Iteme 23a or the Medical Examiner must be re-23a 3407 East Joppa Road 21234 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Saltimore. Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 XWidowed 4 □ Divorced White "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) t. Pages 1 and 2 should be filed w treent of Health and Mental Hygie rtent: if Item 27 is marked other t niury or other treumatic event, ID Machine Operator 11 Black & Decker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Henry Zander Edna <u>Hartlove</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon H. Dietz, Sr. (son) 2509 Roy Terrace - Fallston, Maryland 21047

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: if any injury or pnos. 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery 09/24/2007 Baltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee S 6 ao 11750 Belair Road - Kingsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Frchen POT /Medical Due to (or as a consequence of) Examiner covoner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physiclan/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 s autopsy performed periphera occlusive Piscasa Vital 1 ☐ Yes 2 ☐ No 1□ Yes 2□No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA of funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Hatural 2 Accident 5 Pending Injury death. nerei Director; A filled in by the fu 1 Yes 2 No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerei I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m John Coh 1124 Mace 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2 1 2007 Market . Registrar

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			1 - State Registrar	e of Maryland / Dep <i>Ce</i>	partment of Health Prificate of Deat	h	2007	30305
	Physici		1. Decedent's Name (First, Middle, Last)	Englis	h	2. Date of Death Month	Day 1t 2 Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street as	nd number)	4b. City, Town, or Location		4c. County of Death	110
	Funeral		5. Social Security Number 6. Sex	5. ge (In yrs. last birthda)	/) If Under 1 Year If Und Months Days Hours	er 24 Hrs. 8. Date of Birth	9. Birthp	place (State or Foreign
	Director	0	219 - 38 - 15 43 MM 20 Usual Residence of Decedent	61		Min. 9-23-19	939 Ma	ryland
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or flems 23a or 28a-1 show evant, the Medical Exeminer must be nutified at	tor	10a. State 10b. County	10c. City, Town or I	more		1	0d. Inside City Limits 1 1
	with the a or 28a	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Cour	ntry?
	er death	Funeral	11 Marital Status 12. Was	Decedent Ever in U.S. 13	. Was Decedent of Hispanic (If Yes, specify Cuban, Mexic	Origin? (Specify Yes or No- an, Puerto Rican, etc.)	14. Race - Americ Black, White,	
5-0036	ours after al', or it Exemin	by	1 Never Married Married 1 If Ye	Yes 2€ No es, Give r or Dates:	1 ☐ Yes 2 Mo Specif		Specify:B/C	ick
15-0	in 72 ho natur	Completed	15. Decedent's Education (Specify only highest grade compl	eted) (Giv	edent's Usual Occupation re kind of work done during m DO NOT use retired)	ost of working	b. Kind of Business/Inc	dustry
12121	filed within Hygiene. othar than "		Elementary/Secondary (0-12) Coll 17. Father's Name (First, Middle, Last)	ege (1-4or 5+) AU	to Mecha	Nic	A Uto	
Maryland	should be found that we have a marked of umatic even	To Be	Samuel Englisi	SR	10. Mil	ildred Je	NKINS	
Man	nd 2 should lith and 27 is m		19a, Informant's Name/Relation in (Type, Print)	196. Mai	ling Address (Street and Num	nber or Rural Route Number, C	City or Town, State, Zip	21139
ore,	0 0		20a. Method of Disposition Burial 2 Cremation 3 Removal	20b. Place of Disp cemetery, cri	position (Name of ematory or other place)	Date 20	c. Location - City or To	7/2
Baltimore	t. Pa tmen tant: ijury		`4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee	Arbutu	S OM e toy	9/26/07 F	altinon	C, MD
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	Pnysician		shock, or heart failure. List only one caus Immediate Cause (Final disease or condition	on each line.	mor the mode of dying south	as our diag or respiratory arres		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	ue d (or as a consequence of):	Lacterro		É	gue week
7.	ed	Jiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course Creates of the year that initiated events c.	ue to (p) as a consequence off:	Jacoba			
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6876	ificate b g physic as the bi	edicai	d					
Вох	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Medio	in the past 12 months?		☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	ery Day Year
P.O.	at the de 1 by the a stached	Physic	9 Unknown 9	Unknown				
	quires that n signed t uld be det	by	Part II. Other significant conditions contributin	g to death but not resulting in the	underlying cause given in Par	1 \(\text{Yes}	cco use contribute to the 2 No 3 Prob	
Seco.	e law require has been si je 2 should t	Completed				24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of
Vital Records,	Th ate pag	Be Cor	25. Was case referred to medical		26. Pla		No 1 ☐ Yes	2D U NO
of V	Phys this ral dii	۵	examiner? 1 Tyes 2 No Hospital: 27. Manner of Death 28a.	1 ☐ Inpatient 2 ☐ ER/Outpatie Date of Injury 28b. Time		Nursing Home 5 Residence		iy)
Division	Attanding I r death. actor: After by the funer	cation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury		□No		
Divi	al or Attands after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e.	Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	N Route Number,
	within 24 hours after de vithin 24 hours after de To the Funaral Direct completely filled in by the	edical ((Check only 2 Medical Examiner: On	To the best of my knowledge, dea the basis of examination and/or i manner stated.	ath occurred at the time, date investigation, in my opinion, d	and place, and due to the cau eath occurred at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
	within 2 To the complex	Me	29b. Signature and title of certifier Duesch K. T	riperarer	29c. License number D 306	1 / 1	Date signed (Month,	
	Q		30. Name and address of person who completed	I cause of death (Ijem 23a) (Type			- 2123	39.
	Sta		31. Date filed (Month, Day, Year)	32-Registrar's Signature				
DH	Registr MH 17 Rev 1/20	· E.	SEP 2 1 2007	The State of	well)			
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07-07129 Edna Fordyce Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 30306

		- For State			Cei	rtificat	te of i	Death				Re	eg. No	-	0 1	0000
Physicia		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year											ne of Death			
ledical Examin		EDNA MAE	FORE	YCE								Septembe	er 13, 200)7	16	554 hrs
		4a. Facility Name (if not insti	ution, giv	e street and n	umber)		4t	c. City, To	vn, or Lo	cation of	Death	15 P		unty of Dea		
		Laurel Regional Ho	spital				- 1	Laurel		• 55			Princ	ce Geor	ge's	
Funeral		5. Social Security Number	6. S	ex	7. Age (In yrs.	last birthd	lay)	If Under	1 Year	If Under	24Hrs.	8. Date of Bir	th(MM/DD/\			(State or
Director		472-38-7321	4	M 2XXF	-	74	Yrs.	Months	Days	Hours	Min.	Feb.	26 10		eign Country) į	Montana
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· ····································		Usual Residence of Deceder 10a. State 10b. Cou			10c. City	, Town or	Locatio	n							10d.	Inside City Limits
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Maryland 28a-f show d at once.	후		ice G	eorge'	s Laı	ırel		401 7 - 0	- 1 -			- 14	0g. Citizen	of Mihot C	ountry?	
with the Maryland ns 23a or 28a-f sho be notified at once,	Director	10e. Street and Number						10f. Zip C	oge			1	og. Cilizeri	DI WITAL C	ouritry:	
3a or		7522 Haines	Cour	t				2	070	7	W		US			
with 2 ms 2.	Funeral	11. Marital Status	_		cedent Ever in U	J.S.		Decedent				cify Yes or No		Race - Am White, etc		dian, Black,
or iten	Ĕ	1 X Never Married 2	Married	1 Yes	2X No		11 10	s, specify	Cuban, i	vicxicaii,	i delle i l	out, oto.,		Trinto, oto		
ifter II", o		3 Widowed 4	Divorce	or Dates:			1	Yes 2	No	specify:			Spe	ecify: W	hite	
15-0036 filed within 72 hours after death with the Maryland I Hygiene. do other than "natural", or items 23a or 28a-f she i, the Me iscal Examiner must be notified at once	함	15. Decedent's Education	Specify o		de completed)			s Usual O					16b. Kind	of Busines	ss/Industr	У
n "na	Completed	Elementary/Secondary (0	-12)	College	(1-4 or 5+)	7 "	uring mo	SLOT WORK	ng ille. L	JO NOT	use retiret	u) .		Tows	on	
D36	림	12th		5+		Pr	cofe	ssor					Stat	e Un	iver	sity
ed wi	हो	17. Father's Name (First, Mi	ddle, Last	1)		•			18	.Mother's	s Name (F	First, Middle,	Maiden Sur	name)		
215 be fill ntal H rked ent,	Be	Millard Aard	n Fo	rdyce						Crys	stal	Arvil	le Spa	eth		
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Me fea		19a. Informant's Name/Rela	ionshîp (Type, Print)		19b.	Mailing	Address	(Street	and Num	ber or Ru	rai Route Nu	mber, City o	r Town, St	tate, Zip 0	Code). **. *
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more, M Pages I and 2 ent of Health int: If item 2		20a. Method of Disposition			20b.			tion (Name	of ceme	etery,	**	Date	20c. Loca	ation - City	or Town	State
Or ges 1 rt of 1 of her		1 Burial 2 Crem	ation 13	X Removal	from State	cremator	-	er place) emete	 .		0 /2/	5/2007	Conr		Mont	ana
tinent rand	- 1	4 Donation 5 Other 21. Signature of Funeral Se			hir	TISIC				of Eacility		aldson				
Baltimore, permit Pages I at Department of Hee Important: If ite	- 1			7-00	V)	100										p.A.
		23a. Part I. Enter the diseas	or com	nlications that	M01		enter th	e mode of	dving s	uch as ca	enue,	Laur	rest, shock.	or heart		proximate Interval
Physician /Medical		failure List only one c	ause on e	ach line.					ayg, 0							tween Onset and Death
xaminer	1	Immediate Cause (Final disor condition resulting in dea			ive Cardiova		Disea	se		-	-				+	
	- 1	or container resenting in dec	,	Due to (or as	a consequence	or):				2 * 100 4	* P .	7 m				
	ᡖ	Sequentially list conditions, if any, leading to immediate	L	Due to (or as	a consequence	of):				-	14.					
	Ē	cause. Enter Underlying Confidence (Disease or injury that initial	use							A STATE						
/ _ 4	Examine	events resulting in death)		Due to (or as	a consequence	of):									1	
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8760, tificate being physicias the buri	B	IF FEMALE:		23c. If yes	, outcome of pre	gnancy								ate of deli	-	
687 ertific ding 1	an/	23b. Was decedent pregnan past 12 months?	in the		birth			al death	3	Ectopic	pregnan	су	Mo	onth	Day	Year
Box 68 le death certi the attendin ted for use a	Sici	1 Yes 2 V No 9	Unknow	m - =	gnant at time of o	death 5	Oth	ner (Spec	fy)							
hed f	اچ	Part II. Other significant c		9 Olik	nown	ropulting	in the u	ndoelvina	nouso ai	von in Do	ort I	23e Did	tohacco use	e contribut	e to the c	ause of death?
P.O. Box 68 s that the death cert med by the attendir etetached for use a			JIIGILIOIIS	Contributing	to death but not	resulting	III (IIIe u	nuenying	Jause gi	veii iii i c						4 Unknown
S, P.C.	Completed by	Cirrhosis of Liver														findings available
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that it rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach		25. Was case referred to m	edical					2	6.Place	of Death	(Check or	nly one)				
lita sicla is cer	Be	examiner?		Hospital: 1	Inpatient 2	/ ER/Ou	tpatient	3 D	DA C	Other,	Nursing	Home 5	Residence	e 6 C	Other:	
n of V ing Phy After th funeral o	욘	1 Yes 2 No		128a. Da	te of Injury	28b. T	ime of I	njury 2	Bc. Injury	at Work	? :	28d. Describe	e how injury	occurred		
ding h. Af	悥	1 Natural 5	Pending	i (Moi	nth, Day, Year)				1 Y	es 2	No					
Sio	g	2 Accident	Investiga	ation 280 Pl	ace of Injury - At	home far	rm stree	et factory	office by	ilding el	tc	28f. Location	(Street and	Number c	r Rural R	oute Number, City
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Espita sspita hours neera y fille		4 Homicide 29a. Certifier	_	1000							- 1				atatad	
Division To the Hospital or Attency within 24 hours after death To the Funeral Director:	g	(Check only Certify	ng Physi LEvamin	cian: To the b er:On the hasi	est of my knowle s of examination	edge, dea and/or in	th occur	red at the	time, da	te and pla death or	ace, and o courred at	due to the ca the time, dat	use(s) and n e and place	nanner as and due	to the cau	use(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical			and manne	r stated.	. unurot III	. rounyal				ut			te signed		
	Σ	29b. Signature and title of o	ertifier	10				290		number						
		Cler	el	HU	ldi	1	-		O.C.N	/I.E.			Septe	mber 14	4, 2007	
nh		30. Name and address of p														
10		Carol Allan, MD	Assis	tant Medica	al Examiner	111 [Penn S	Street, E	Baltimo	re, MD	21201					
St	ate	31. Date filed (Month Pay	(89r) 1	2007 32.	Redistrar's Signa	ature	A	esti)	,							
Regist	rar	JLF	M T	2001		10	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death SEPTENSON 14, 2007 **Physician** n Er ler -IZANKINA /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner new of Illabour 11 North weit CNER If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Days Hours Director 232–38–4887 Usual Residence of Decedent M Anch 13,1934 West Virginia Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any, if Item 27 is marked other than "hatural", or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 □ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1032 West Barre Street 21230 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Tyes 2 □ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify. 2 Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Geologist U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willard Wesley Franklin Dixie Dale Roach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Shawn Franklin / Son 3 South Reed Street, Bel Air, Maryland 21014 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important; If any Injury or once, 4 Donation 5 Other (Specify)

21. Si Jaur of Fund Serve Linesee Baltimore Nat'l Cem. 9-20-07 Baltimore, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SACTEREMIA /Medical e to (or as a consequence of): Examiner Andiomyog Sequentially list conditions, if any leading to inneclat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) n signed by the a P.0. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy page this certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 1 Yes 2 No

27. Manner of Death
1 Natural Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accounted to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

¥1 /

State Registrar Court ROAD, RANDALLETOWN, MD

PAO

 $_{e}Old$

32 Registrar's Signature

30. Name and address of pason who completed cause of death (Item 23a) (Type, Print)

2007

Steven Rylle

31. Date filed (Month, Day, Year) SEP 2 1

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September N, 2007

			For State	State of Mary		partment of F				7	30308
			Registrar		C	ertilicate of	Deam	2. Date of Death	9.110.		3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, L	ast) T I	-loov			Month	Day _	Year	
	/Medic		ROVERT	in atmost and numbers	ICCA	4h City Town o	r Location of Death	September	4c. County	007	08:06 AM
	Examin	er	4a. Facility Name (If not institution, gi Johns Hopkins Bayv		Center	Baltiv		1	N/		
	Francis				In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	9. Birthp	place (State or Foreign
	Funeral Director		220-66-2339	1M 2□F 52	Yrs	Months Days	Hours Min.	(Month, Day,		Couir Mar	ovland
	p		Usual Residence of Decedent		- 0: -						(0.1.1
	trylar show	_	10a. State 10b. County	10	0c. City, Town or	Location				'	10d. Inside City Limits 1 ☐ Yes 24☐ No
	Ba-f s	Director		timore			Dundal		a. Citizen of W		
	vith th		10e. Street and Number	77		10f. Zip Code					
	s 23e	Funeral	7329 Stratto	n way 12. Was Decedent Eve	ar in IIS 1	21224	lispanic Origin? (S		United 14. Bace		can Indian,
	Item Iner	Ľ,	11. Marital Status1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕅 No	31 117 0.0.	 Was Decedent of F If Yes, specify Cub 		o Rican, etc.)		k, White,	
39	al", or	ρ	3 ☐ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify.	W	nite
Ģ	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest of	Education	16a. De	cedent's Usual Occupive kind of work done	ation	rkina 1	6b. Kind of Bu	siness/In	dustry
215	thin 7 e. an "r Med	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life	e. DO NOT use retire	d) -	Karg			
21	ed wi	ပ္ပ	4 Years			orywall Fi		(F) (A) (A) (A)	Constr		Lon
n	be fill d oth even	Be	17. Father's Name (First, Middle, Las	şt)				ne (First, Middle, M		e)	
<u>Ş</u>	should be nd Mental marked o	Ţ	James D. Flee		105.14	ailing Address (Street	Gla	*		Ctoto 7	n Codal
Maryland 21215-003	S 65 65		19a. Informant's Name/Relationship Annie M. Fleek	(Daughter		29 Stratto		undalk, M			1224
o,	is 1 and 2 of Health a item 27 is other trai		20a. Method of Disposition	(Daughter	20b. Place of Di	sposition (Name of		Date 2	Oc. Location -	City or T	own, State
D D	Pages nent of int: If its		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State		rematory or other pla Service C		4/2007	Towson	. Ma:	rvland
Baltimore,			21. Signature // Funeral Service Lie		1/1/200	OO Nome and Addre	on of English		- 17		-
Ba	permit. Departr Importa any Inju		V md 10	1 Aml	11	Duda-Ruck	Funeral	Home of	Dundal	k, 11 1 21:	nc. 222
F			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused th	death. Do not	enter the mode of dyi	ng, such as cardia	or respiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final			orillation					Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a c		of the tree to					1 VIOLEV
	Examiner		Sequentially list conditions	b. Chranic ok	structive	L pulmonar	y diseas	e			25 yeurs
24	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	consequence of):						
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
90,	cate be executed oblysician and the burial-transit		loosing in dodai, 2001	Due to (or as a c	onsequence or).						
8760	physic the t	dical		d							
9 X	The law requires that the death certificate has been signed by the attending plate 2 should be detached for use as I	Physician/Me	IF FEMALE:	23c. If yes, outcome pf	pregnancy				23d Dat	te of deliv	rerv
Box	atter atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 4 ☐ Pregnant at tir	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	У			nth	Day Year
o.	the c y the	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown							
<u>ر</u> م	w requires that the d been signed by the should be detached	by Pl	Part II. Other significant conditions	contributing to death but	not resulting in th	e underlying cause giv	ven in Part I.	23e. Did tob	acco use cont	ribute to t	the cause of death?
ğ	quire en sig uld b							1 ½ Ye	s 2∐No	3 ☐ Pro	bably 4 □Unknown
ပ္က	aw re Is bee	plet						24a. Was an	24b. \	Were aut	opsy findings available ompletion of cause of
Vital Records,		Completed						perform 1 Yes 2	ned?	death?	2 □ No
<u>ta</u>	sician: The law certificate has b irector, page 2 s	Be C	25. Was case referred to medical examiner?	A STATE OF THE STA			26. Place of De	ath (Check only one			
<u> </u>		70	1 Yes 2 No	Hospital: 1 ☐ Inpatient		ment 2 DOV		lome 5 Reside		- ' '	ify)
חַ	Attending Physician: r death. ector: After this certifics by the funeral director, I		27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	/ear) 28b. Tim	y Wo		28d. Describe ho	w injury occurr	ed	
Sio	ttend death. tor: /	cati	2 Accident investigat 3 Suicide 6 Could not	h -	At home farm	M 1 street, factory, office]Yes 2□No	28f Location (Str	reet and Numb	er or Ru	ral Route Number,
Division or	il or Attending Phy after death. I Director: After this d in by the funeral c	Certification:	4 Homicide determine		(Specify)	street, factory, office		City or Town	, State)	er or nur	ar noble Number,
_	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier Certifying	Physician: To the best of	my knowledge. d	eath occurred at the t	ime, date and plac	e, and due to the ca	ause(s) and ma	anner as	stated.
	24 hos 24 hos Fur e Fur	Medical	(Check only 2 Medical Ex	raminer: On the basis of e	xamination and/o	r Investigation, in my	opinion, death occ	urred at the time, da	ate and place,	and due	to the cause(s)
	Fo th within Fo th	Me	29b. Signature and title of certifler)	29c, Licen	se number	29	9d. Date signe	d (Month	, Day, Year)
			2/1	2 2	-	RES	-000	> 5	Enten	wer !	17 2007
•	1		30. Name and address of person wi	no completed cause of dea	th (Item 23a) (Ty	pe, Print)			1.		
	7		Terrene Brown	M)	491	o Eastern	Ave. B	cattimore,	MD, 21	224	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	pe, Print) DEASKIN					
	Regist	ar	0L1 7 T L	THE STATE OF THE S	15 19	ASTRONOM TO THE PARTY OF THE PA					

State of Maryland / Department of Health and Mental Hygiene 30309 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 20,2007 9:20 A M Lee Edward Griffee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Parkville Baltimore Crest Care Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 921 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Maryland 213-14-2995 85 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Parkville Director Baltimore MD 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 21234 USA 8810 Walther Blvd. Apt. 1103 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 □ Yes 2 No 3altimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Post Office Desk Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Myrtle Schuyler Jinks Griffee ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Griffee-spouse 8810 Walther Blvd.Apt.1103-Parkville, Maryland 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Lakeview Memorial 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 24,2007 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8800 Harford Road EVANS FUNERAL CHAPEL AND CREMATION SERVICES Condiae h N Parkville,MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. AlZheimens Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached Ö 9☐Unknown 9 Unknown ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2/2/No 1□ Yes or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Division Hospital or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Cirector: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Discompletely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10030972 30 Name a ddress of person who completed cause of death (Item 23a) (Type, Print) 8800 Walter Hud Rankuile mo MD GIVA 32. Registrar's Signature 31. Date filed (Month, Day, Year) 13.00 Registrar

07-07011 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Patricia Gray 1- For State Certificate of Death Reg. No. Registra 2. Date of Death ame (First, Middle,Last) Physician/ 1628 hrs **Medical Examiner** September 9, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 227 North Patterson Park . Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director Usual Residence of Decede 10d. Inside City Limits any 10a. State 10b. County 10c. Citv. Town or Location 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Marital Status 12. Was Decedent Ever in U.S. White, etc 2 Armed Forces? Never Married Yes 0 3 Widowed Divorced If Yes, Give Year Yes 2X No specify ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr Completed during most of working life. DO NOT use retired) College (1-4 or 5+) If item 27 is marked other than her traumatic event, the Medical 21215-0036 's Name (First, Middle, Last Be ٩ 19b. Mailing Address 20c. Location - City or Town, State 20b. Place of Disposition (Nar ltimore, crematory or other place) Burial 2 Cremation 3 Removal from State tment (Donation 5 Other Specify Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi Physician/Medical attending physician a UNPENDED **AMENDED** Box 68760. IE EEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) The law requires that the death 1 Yes 2 No 9 V Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o þ Yes 2 No 3 Probably 4 V Unknown σ. Completed Records, peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? Yes 2 ✓ No Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical or Attending Physician: of Vital Be examiner? Other₄ Residence 6 V Other: Scene ER/Outpatient 3 DOA Nursing Home 5 Inpatient After this 1 V Yes 2 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Division Natural Yes 2 No death. Pending Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after 3 Could not be Suicide or Town, State) determined (Specify) To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME September 18, 2007

5

State

Registra

Assistant Medical Examiner

sistrar's Signatur€

BULL

30. Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD

31. Date filed (Month, Day, Year

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 09 0200 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deat Town, or Location of Death Examiner Si nai Baltimore Cit Hospital tbaltimine 9. Birthplace (State or Foreign Country) Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, AUG-07 7. Age (In yrs, last birthday) **Funeral** Days Year 36-8632 1 M 2 K Months Hours Min. Director MAR Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ıral", or items 23a or 28a-f show Examiner must be notified at 1XYes 2 No Funeral Director 10e. Street and Number og. Citizen of What Country? 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examine once. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Marvland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 € Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ary/20 condary (0-12) College (1-4or 5+) grade 18. Mother's Name (First, Middle, Maiden Surname) rst Middle Be 2 19a. Informant's Name/Relationship (4 19b. Mailing Address (Street and Number or Hural Route Number, City or Town, State, Zip Code, WAL)AUGH 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □ Removal from State BALTIHORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses JR, FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Physician Stake TL 5 yrs /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to bacco use contribute to the cause of death? ò 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 s autopsy performed? Yes 2 No certificate ha 1∐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Many r of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. 18,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Morey Hospital 31. Date filed (Month, Day, Year) State 2007 Registrar 2 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30312 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** ೨೦೭≾ [≜]м Wilhelmina Joanna Glenn 30 2007 Deftember /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** BALTIMORE AGNES HEALTHCARE If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗶 F 578-32-6515 88 Director JAN 26 1919 DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4405A Fairview Avenue 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Administrator. Department of Licensing & Professions 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry District of Columbia Elementary/Secondary (0-12) Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Williams ပ Alice Gilmore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilhelm B. Glenn - son 4509 W. Forest Park Avenue, Gwynn Oak, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 9/20/2007 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Cremation Society of Maryland,
299 Frederick Road, Baltimore. Williams 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION **Physician** 16 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 R/Outpatient 3 DOA 1 Inpatient မှ After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation al or Attend s after death filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. (Check only one)

State

29b. Signature and title of ertifie

31. Date filed (Mont)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 290 per dr., g871, 09/21/07dhb Gar Certificate of Death Reg. No. Reg. No 2 0 7 303 L 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 10 **Physician** MINNIE GOLDKLANG 2007 5:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTH OAKS HEALTH CENTER PIKESVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 12/20/1914 Birthplace (State or Foreign Country) 5. Social Security Numbe Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Months Days Hours Min. 212-03-1964 92 RUSSIA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If the ZT Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Funeral Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 HAMILL COURT. #48 21210 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BRONSTEIN BENJAMIN SARAH WEINSTEIN ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 HAMILL COURT, #48, BALTIMORE, MD 21210 STEPHEN GOLDKLANG / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State **FORBAND** 09/12/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature J Funeral Service Licen lee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Concestive 2 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Therosclerohe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner The law requires that the death certificate be executed use as the burial-transi and Due to (or as a consequence of) sate has been signed by the aftending physician apage 2 should be detached for use as the burial Division or Vital Records, P.O. Box 68760. Physician/Medical IE EEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2 **№** No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chec 29d Date signed (Month Day, Year) 2007 and title of certifier 29c. License number 29h Signatur MO 038675 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balhmon 301 21202 MESHULAM ST PL PAUL # 804 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra H Speak

ORIGINAL

2. Date of Death

3. Time of Death

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

DOO! AN

Physicia /Medic		Antonia N	Mary (Gross						Sept.	16	2007	10:01 A M
Examin		4a. Facility Name (If not institution	-)		1		Location of Death	•	4c. (County of Deat	h
3		Suburban H						thesc				Montgom	
Funeral Director		5. Social Security Number 577-44-4932	6. Sex	7. A	ge (In yrs. I	ast birtho	Month:	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 9	Year) 193	9. Birti Co. 35 Wash:	hplace (State or Foreign untry) ington, DC
and w		Usual Residence of Decedent 10a. State 10b. Count			10c. City	/. Town o	r Location						10d. Inside City Limits
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the N	rect	10e. Street and Number					10f. Z	ip Code			10g. Citiz	en of What Co	untry?
3a or		6121 Montrose	Road	#318				208	352		Unit	ted Sta	tes
deatl	Funeral Director	11. Marital Status	12	. Was Decedent Armed Forces	Ever in U.	S.	13. Was Dec	edent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	1	14. Race - Ame	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce		1 ☐ Yes 21€ If Yes, Give Year or Dates:	No		1 ☐ Yes		Specify:	riidan, etc.)	- 1	Specify: B1	
2 hou latura ical Es	ted	15. Decede	ent's Educat	tion		16a. D	ecedent's Us	ual Occup	ation	. 1	16b. Kir	nd of Business/	Industry
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narke	၉	19a. Informant's Name/Relation				105.10	4 - 10: A -d -d	(011					
d2sh thand 7 is n traun		Lynne M. G.			ter	1	-		and Number or Rur Blvd , Di				,
Heal Heal tem 2		20a. Method of Disposition			20b. P		isposition (A			Date		cation - City or	
ages ent of it: if if		1☑ Burial 2☐Cremation 4☐Donation 5☐Other (noval from State	J [crematory o			/2007	Clin	ton, Ma	ryland
mit. F bartmoortar injur		21. Signature of Funeral Service		7					ss of Facility Por				
Der Imp		+ KOSHAG	Ale	va 104	0108	3-							land 20747
		23a. Patta Liter the disease, shock, or heart failure. L	r complica	tion that cause	ed the death	n. Do not	t enter the m	ode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		Sepsis									Onset and Death
/Medical		resulting in death)	Ca.	Due to (or as	s a consequ	uence of)	:						
Examiner		Sequentially list conditions,	b	Billowe				lluli	tis				Unknown
cuted Id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1 .	Chronic									Unknown
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the d	ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	230	c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Feta	death	3□Ectopic 5□ Other		у		2	23d. Date of del Month	livery Day Year
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ilan: artifica ctor, p	Be C	25. Was case referred to medic examiner?	al						26. Place of Deat				29.110
hysic his ce I dire	70	1 ☐ Yes 2 ☑ No	Ho	spital: 1 Inpat	tient 2	ER/Outp	atient 3	OOA Oth	er: 4 Nursing H	ome 5 ☐ Resid	dence 6	6 □Other (Spe	cify)
Attending Physician: r death. ector: After this carlifica by the funeral director, I		27. Manner of Death 1 Natural 5 □ Pend	ling	28a. Date of In (Month, D	jury Pay Year)	28b. Tin Inju	ıry	28c. Injui Wor		28d. Describe I	ow injur	y occurred	
ttend leath. tor: / the fi	cati	2 Accident inves	stigation	One Diago of in	aire At be	ma form	M		Yes 2 □ No	006 Lanation (244	d \$4	
i or Attend after death Director:	Certification	4 ☐ Homicide deter	rmined	28e. Place of ir building, e	etc. (Specif		i, street, lact	ory, onice		City or Tov			ural Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical Co				of examina				me, date and place opinion, death occu				
Fo the within of the complex	Me	29b. Signature and title of certif	fier				- 2	9c. Licens	se number			e signed (Mont	
FSFO		▶ Desteli	Don	nez	M	D		DOC	06299	9	ept	rembe	~ 17 200.
6.		30. Name and address of personal Dr. Petek Do						Road,	Bethesda	, Maryl	and	20814	
Sta	te	31. Date filed (Month, Day, Yea			trar's Signa	ature	100						
Registr	ar	CED	2 1 7	nnt le	10121	15	Local	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30315 Reg. No 2 [] 7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Sept. 20, 2007 **Physician** 1:20a м Donald Thomas Milton Golden /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 2803 Hernwood Road Woodstock 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 20, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1924 1 M 2 □ F 215-20-7319 82 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lipury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🙀 No Director MD Baltimore Woodstock 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2803 Hernwood Road 21163 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: WW 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🎇 No Specify Specify: White þ WWII 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Technician Electronics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edgar J. Golden Julia Henderson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2803 Hernwood Road Woodstock, MD 21163 19a. Informant's Name/Relationship (Type. Print) Mrs. Evelyn Golden (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/24/07 Linganore Cemetery Unionville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature A Funeral Service Licensee AAIGHT FUNERAL HOME & CHAPEL, P.A. (Box 195) M00764 Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MC603 Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of): Examine physician and s the burial-trans Due to (or as a consequence of): Completed by Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to acco use contribute to the cause of death? 2□ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Besidence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA ၉ 1 Inpatient 27. Manner ath 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Lural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, been signed by the should be detached certificate has be irector, page 2 s r this c s after death.

I Director: After this of in by the funeral d within 24 hours aft To the Funeral Di completely filled in

Baltimore, Maryland 21215-0036

State Registrar

Medical

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 🗌 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person

31. Date filed (Month, Day, Year)

29a. Certifier

32. Registrar's Signature 2007 1 SEP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Vincent Wells Gallo 3:00 2007 September 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Pennsylvania 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F 204-14-0349 82 Director February 17, 1925 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "naturat", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore Timonium 1 Tyes 2 X No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Pot Spring Rd., K505 21093 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. Specify: ģ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) real estate broker real estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theresa Volpe Peter Gallo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 2525 Pot Spring Rd., K505 Timonium, MD Virgie Gallo/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory Sep. 20,2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee John O. Mitchell IV, Funeral Services of Dulaney Valley. P.A. 200 Padonia Rd. East Timonium,MD 2109B Valley, P.A. 23a 1911. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) the burial-Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FFMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9□Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1☐ Yes 2X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE ျ 1 ☐ Yes 2 ▼ No 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation (Month, Day Year) Injury 1 TYes 2 TNo 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier X CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check o 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

17

State

SEPTEMBER 18, 2007

VINCENT GALLO

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

SEP 2 1 2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#20b,c,perfH,63/1,9/21/0/,wo State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2007 1 - For State Registrar 30317 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day 50 A a eplember 18, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 46. City. Town, or Location of Death 4c. County of Death **Examiner** Hmore
Par If Under 24 Hrs.
Min. masitan 7. Age (In rs. last birthday) 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1□M 2□F 18-320 Months Days Hours Min. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Kes 2 No Funeral Director MARYLAND 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ō or items 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; any injury or other traumatic event, the Medical Exa once. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RESS 12 + MGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majdeft Surname) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Statt 19a. Informant's Name/Relationship (Type. Print) HARINE LARK GRAND DAUGHTE SHADVSIDE MΔ 21218 20a. Method of Disposition 20c. Location - City or Town, Laurel Maryland Mary land Natery Pr Charplace) 1 Burial 2 ☐ Cremation 3 Removal from State 5 ☐ Other (Specify) 22. Name and Address of acility 2 (4) 21. Signature f Funeral Service Licensee MD21219 1501+1mor Joseph 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Gorellan 1 /Medical Due to (or as a consequence of) eal Gne Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760 physician Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Munknown 1 🗌 Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 € No 24a. Was an has autopsy this certificate 2/No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 🔲 Inpatient 1 Tyes 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at/ Work? 28d. Describe how injury occurred Medical Certification: After 5 ☐ Pending investigation 1 Natural 2 ☐ Accident within 24 hours area
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) Suplement 18 12007 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balli mole 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Plea

		State of	Maryland / D				Mental Hy	giene 0	07	30318
				Certific	cate of	Death	2. Date of Dea	Reg. No.		3. Time of Death
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		3 □Removal from S		ry, crematory	y or other pi		Date 8/13/07	20c. Location Culpep		
21. Signature of F	uneral Service	Licensee				ress of Facility en Funer	al Home	721 E1 Herndo		
ODD DOT FRAN	the disease or	- What	used the death. Do	not enter the				- 4	1	Approximate
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Immediate Cause	(Final		FAILURG	Consequenc	O e of):		F	rrest,		Interval Between
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29d. Date signed (Month, Day, Year)

9(21107

Physician /Medical Examiner

Examiner

Physician

/Medical

Examiner

Funeral Director

Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland

Baltimore, Maryland 21215-0020

Department of Health and Mental Hygiene. Important: or items 23a or 28e-f show important: if item 27 is marked other than "natural; or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once.

29b. Signature and title of certified

Director

Funeral

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Completed

Be

Division of Vital Records, P.O. Box 68760, Be Completed by Physiclan/Medical

within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the bunal-trinsit To the Hospital or Attending Physician: The law requires that the death certificate be exec ted

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Certification:

edical

State Registrar

TRUONG BAC 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9715 MEDICAL CENTER DR. #201 ROCKVILLE, MD. 20850
32 Registrar's Signature foul

29c. License number

00057124

DHMH 16 Rev 6/95

			1 - For State of Maryland / Dep Registrar	partment of Health and Nertificate of Death		ne 2007 30319
ja ja	Physici	an	1. Decedent's Name (First, Middle, Last)	Handy	2. Date of Death Month	Day Year 3. Time of Death
R.	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town or Location of Death	7 /	4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	BAH-noll (1) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director	3	Usual Residence of Decedent		JANUARY I	
	Marylar a-f show	tor	10a. State 10b. County 10c. City, Town or I BALTI	MORE CITY		10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	with the 3a or 28 t be not	I Dire	10e. Street and Number 1221 N-PARRISH STREET	10f. Zip Code 2/2/7		Citizen of What Country?
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto □ Yes 25 No Specify:	ecify Yes or No-	14. Race - American Indian, Black, White, etc. Specify: BLACK
1215-0036	within 72 hou iene. 'than "natura 'the Medical E:	Completed I	15. Decedent's Education (Specify only highest grade completed) (Giv Illie. Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation ne kind of work done during most of work DO NOT use retired) RKLIFT DPERA	ding	o. Kind of Business/Industry
nd 21	oe filed val Hygie I other t vent, th	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	den Surname)
Maryland	2 should be fi and Mental H Is marked ot aumatic ever	Į.	19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ROSII		SCOTT ity or Town, State, Zip Code)
	1 and 2: Health ar em 27 Is wher trau		CHRISTINE HARRIS (DAUGHTER) 915 20a. Method of Disposition 20b. Place of Disp			C. Location - City or Town, State
Baltimore,	Pa Int:		1 █ Burial 2 □ Cremation 3 □ Removal from State	ematory or other place)		ALTIMORE, MARYLAND
Balt	permit. Pag Department Important: I any Injury o		1 / / / / / / / / / / / / / / / / / / /	22. Name and Address of Facility 505 EPH H. BROWA 2740 N. FULTON A	J JR. FUR	NERAL HOME MORE, MD 21217
	Ob. objection		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final			
1	Physician /Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):	016 142		
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events.			
0,	icate be executed physician and sthe burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C			
68760,	ificate be physici s the bu	edical	d		_	
P.O. Box	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	uires that signed b Id be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Records,	he law require e has been si age 2 should t	Completed			24a. Was an autopsy performed	
Vital	Physician: The this certificate har director, page	Be	25. Was case referred to medical examiner? Hospital:	Othori	1 Yes 2 ■ th (Check only one)	No 1 □ Yes 2 □ No
o	ng Phys fter this ineral dir	on: To	1 Yes 2 Ao	of 28c. Injury at	ome 5 ☐ Residence 28d. Describe how i	e 6 □Other (Specify) injury occurred
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No street, factory, office	28f. Location (Stree City or Town, S	nt and Number or Rural Route Number, State)
ш	Hospital	Medical Ce	29a. Certifier (Check only one) 1 PCertifyIng Physician: To the best of my knowledge, deal (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2	Mec	29b. Signature and title operatifier	29c. License number	29d.	Date signed (Month, Day, Year)
	V 1		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		9-192007 BALtimore, MJ21201
4	oT 1		LAMONT C Smith, MD 31. Date filed (Month, Day, Year) \$2: Registrar's Signature	10 NGREENE.	Street E	SALtimore, MJ21201
2	Sta Registr		SEP 2 1 2007	we		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death _Month **Physician** 2007 wnng /Medical 4c. County of Death Facility Name (If not institution, give street and 4b. City, Town, or Location of Death Examiner olumbi DVICN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□M 2√F Director 063-36-5762 26, 1944 New York Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f show or 28a-f show be notifled at 1 ☐ Yes 2 ☑ No Director Harford Maryland Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 305 Tiree Court death v 21009 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify by Specify. 3 ☐Widowed 4 ☐ Divorced White Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 Inent of Health and Mental Hygiene. Int: If item 27 is marked other than "nat Iny or other traumatic event, the Medicaling or other traumatic event, the Medicaling or other traumatic event, the Medicaling or other traumatic event, the Medicaling (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lee Carroll Crook Marion Arlene Silvieus 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John V. Higgins Jr. / Husband 305 Tiree Court, Abingdon, Maryland 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) Hilltop Service Corp. 9-21-07 Towson, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. Kissell. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4000 49 010 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to usr as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical the as attending a IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, δ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 2 **X**No 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ۴ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury Division 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of per

31. Date filed (Month, Day, Year) SEP 2 1

ZLOWPAL

son who completed cause of death (Item 23a) (Type, Print)

32, Registrar's Signature

07-06827 Tershea Hurd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	F	- For State Climary and A Department of Treatmand Mental Try Registrar Certificate of Death		Reg. No.	200	7 3032					
Physiciar Medical Examin			2. Date of D Month	eath Day ber 2, 200	Year	3. Time of Deaw U					
neuicai Examini		Tershea G. Hurd 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Septem		ounty of Death						
		Southern Maryland Hospital Clinton	1 - 5-2		nce George	1					
Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of	Birth (MM/DD	/YYYY) 9. Birt	hplace (State or					
Director		579-86-0545 1 M 2XF 47 Yrs. Months Days Hours Min.	_	25, 19	Foreig						
any		Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County		1		10d. Inside City Limits					
≜ .,		Maryland Prince Georges Forestville			,	1 X Yes 2 No					
Maryland 28a-f show d at once.	뢍	10e. Street and Number 10f. Zip Code		10g. Citizer	of What Cour	ntry?					
ith the Maryland 23a or 28a-f sho	Director	2806 Xavier Lane 20747		Unit	ed Stat	- 60					
s 23a		2806 Xavier Lane 20/4/ 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or			can Indian, Black,					
eath i	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	-	White, etc.	1					
	e F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	2 = 1	Sp	Bla	ick .					
ours a atura		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired to the complete of the compl		16b. Kin	d of Business/I	ndustry					
6 72 h ran "n cal E		Elementary/Secondary (0-12) College (1-4 or 5+)	• :	Pr	ivate						
5-0036 led within 72 Hygiene, other than the Medical	Completed	12									
		17. Father's Name (First, Middle, Last) Charles Wilkerson Apports			rname)	4.					
	8 B	Charles Wilkerson Annette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F			or Town. State	. Zip Code)					
sho sho 7 is 7 is 1ati	^[Michael Hurd, Sr. / Spouse 2806 Xavier Lane Fore									
	H	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date		cation - City or						
≥ s J = 9		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	3/2007	Tot	hian, N	ua					
Baltimore, permit. Pages 1 ar Department of He Important: If ite injury or other it	ŀ					iu.					
Dep Imp		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Alexander. S. Pope 5538 Mariboro Piko	ĕ/Fö₽e	stvill	e, Md.	20747					
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	r respiratory	arrest, shock	, or heart	Approximate Interval Between Onset and					
Medical.	ì	Immediate Cause (Final disease a Hypertensive Atherosclerotic Cardiovascular Disease				Death					
Adminer	-	or condition resulting in death) Due to (or as a consequence of):									
	ايز	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		_							
	<u>ا</u> ڇَ	cause. Enter Underlying Cause (Cleans a latin what initiated C. C. C. C. C. C. C. C. C. C. C. C. C.									
events resulting in death) Last Due to (or as a consequence of):											
(0, e be executed ysician and burial - transit		d d				 					
760, cate be e	Medical			024	Data of dolinor						
876 ifficating physis the		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancy		Date of deliver onth	y Day Year					
Box 687 death certific	sician/	past 12 months? 4 Pregnant at time of death 5 Other (Specify)									
Bo le dear the ar	£١	1 Yes 2 No 9 V Unknown 9 Unknown	7.00								
P.O. BO): sthat the deatl gned by the att	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown							
S, P.C uires that a signed I id be deta	pa.	chronic alcohol abuse		24a. Was an 24b. Were autopsy findings available							
ords, aw requires been a special	E E		aı	utopsy erformed?	prior to death?	completion of cause of					
Zec The la	Completed			s 2 No	1 🗸 Y	es 2 No					
Vital Rec tysician: The l	a	25. Was case referred to medical 26.Place of Death (Check examiner?									
F Vir	ᅙ.	1 V Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Nursir	ng Home 5	Residence		r:					
n of ding Pl h. After funera		27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 ✓ Natural 5 Pending	28d. Descri	be now injury	occurred						
ivision or Atten or Atten death Director:	¦ati ati	Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f Locatio	n (Street and	Number or Ri	ural Route Number, City					
Division of Vital Records, rat or Attending Physician: The law requir rs after death. The Director: After this certificate has been is led in by the funeral director, page 2 should be an end in the funeral director, page 2 should be a should be	Certification:	Suicide Could not be determined (Specify)		n, State)		,					
fospit 4 hour funers		29a. Certifier 1 Continue Physician To the best of my knowledge, death accurred at the time date and place and	due to the o	ause(s) and	manner as stat	ted.					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred a	at the time, d	ate and place	e, and due to th	ne cause(s)					
To To Io	ğ.	29b. Signature and title of certifier 29c. License number		29d. Da	ite signed (Mo	nth, Day, Year)					
		Mhna Brassel MY O.C.M.E.		Septe	ember 3, 20	007					
	1	30. Name and address of person who completed cause of death (Item 23a)									
2		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201								
Sta	ite	31. Date filed (Month Dev Year) 1 2007 32. Registrar's Signature									
Registr	ŒΝ										

			1 - For State Registrar		f Marylan		artment rtificate			l Mental Hy	Reg. No U	07	30322
ŀ	Physic /Medi		Decedent's Name (First, Middle, Last) Patricia C. Harris						2. Date of De Month	Day	Year 07	3. Time of Death	
	Examir		4a. Facility Name (If not instituti					Town, or	Location of De		4c. County of Death		
			5.0-3-10	Union Memori						altimore			I/A
ŀ	Funeral Director		5. Social Security Number 212-44-5956 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. 1	Vro	If Under Months	Days	If Under 24 H Hours Mi	n. (Month, Da	th ay, <i>Year)</i> 31, 1945	Cou	place (State or Foreign ntry) Maryland
	/land low at		10a. State 10b. Count	у	10c. City	y, Town or Lo	ocation					1.	10d. Inside City Limits
Baltimore, Maryland 21215-0036	within 72 hours after death with the Maryland liene. I than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	ector	Maryland 10e. Street and Number	N/A			100 =		altimore				1 Yes 2 No
		al Dir	10e. Street and Number 10f. Zip Code 21216						10g. Citizen of	What Coul			
		by Funeral Director	11. Marital Status 1 □ Never Married 2⅓ Ma 3 □ Widowed 4 □ Divorce	Armed Fo urried 1 ☐ Yes If Yes Gir	2 55 No /e		Was Decedent If Yes, special 1 ☐ Yes 2		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	14. Ra Bla Speci	ce - Americ ck, White, fy:	
		Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) Social Worker				luring most of w)	vorking	16b. Kind of E		dustry Maryland		
	1.2 should be filed within? h and Mental Hygiene. 7 is marked other than "! traumatic event, the Med	a	17. Father's Name (First, Middle	charles Jones					18. Mother's N	ame (First, Middle	, Maiden Surna prothy Jon	,	
	permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Examiner once.	2	19a. Informant's Name/Relation							Rural Route Numb timore, Maryl			Code)
			20a. Method of Disposition 1 X Surial 2 ☐ Cremation	3 □Removal from		lace of Dispo emetery, crei	sition (Nam natory or oti	e of her place	9)	Date 09/22/07	20c. Location	- City or To	own, State Maryland
			4 □ Donation 5 □ Other (21. Signature of Funeral Service				Itus Men	Addres	s of Facility			umore,	
	Physician /Medical		23 Enter the Atta ase, shock, or her hallure. Lis Immediate Cause (Final disease or condition resulting in death)	a	Se	1515	er the mode	of dying	utaw Place g, such as cardi	neral Service Baltimore, N ac or respiratory a	d 21217 rrest,		Approximate Interval Between Onset and Death 2 Jays
	The law requires that the death certificate be executed the has been signed by the attending physician and mage 2 should be detached for use as the burial-transit	-		b	or as a cons								/
V		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):										
Vital Records, P.O. Box 68760,		cal	d										
		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		ictopic pregnancy 23d. Date of deliv Dther (specify) Month					ery Day Year			
		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of de 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ #				
		o Be Completed	25. Was case referred to medic							1 Yes	osy rmed? 2 V No	Were auto prior to co death? 1 \(\subseteq Yes	psy findings available mpletion of cause of 2 ☐ No
Š			examiner?	Hospital:/	npatient 2 ☐ E	ER/Outpatien	t 3 🗆 DOA	Othe	r	eath <i>(Check only o</i> Home 5 Resid		(Cif	
n or	ding Ph h. After thi funeral	Ë	27. Mann of Death 1	28a. Date		28b. Time of Injury		c. Injury Work			now injury occur		<u>y)</u>
Division	I or Attending Physician: after death. Director: After this certifica I in by the funeral director, p.	Certification:	1 Metural 5 Pending (Month, Day Year) Injury Work?									al Route Number,	
Ω	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only Check only C										tated.
	To the h within 24 To the F complete	Medical	one) 29b. Signature and title of certific	and manr	er stated.			License			29d. Date signe		
•		-	30. Name and address of persor	who completed cause	of death (Item	23a) (Type. I	Print)	112	4389	146	7/15	10/	11.
6	State 31. Date filed (Month, Day, Year) 32. Registrar's Signature									1 zizi8			
	Registr		SEP	2 1 2007	Wilson	St. A	S COLOR						

07-07189 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1-For Amend #10f Per FH G8/1 9/2 Certificate of Death Tyrone Lee Jones 30323 2007 Rea. No 2. Date of Death I. Decedent's Name (First, Middle,Last) Physician/ Month Day Year September 16, 2007 0119 hrs Medical Examiner Tyrone Lee Jones 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore University Hospital N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Euneral Foreign Country) Months Davs Hours Min. Director 213-04-0761 1 X M 2 F 26 /9/1981 Md. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 No N/A Baltimore notified at once. Md. with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country 21216 3212 Presstman Street USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status nust be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. death 1 X Never Married 2 Married Yes 2X No ō Yes. Give Year Yes 2 X No specify: Specify: Black nours after Widowed Divorced permit. Pages I and 2 should be filed within 72 hours after Department of Health and Méntal Hygiene. Important: If item 27 is marked other than "natural", injury or other fraumatic eyent, the Medical Asambrer. \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Laborer Private Company 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tyrone L. Jones, Wanda Batty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B 3212 Presstman St., Baltimore, Md. (Mother) Wanda Batty 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 9/21/2007 Lansdowne, Md Zion Cemeterv Donation 5 Other Specify 21. Signature of Funeral Service Licen Research Address of Facility Step Brothers Funeral Home 1300Eutaw Place, Baltimore Md 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner 1. 32 C ... cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician or use as the burial Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has b ector, page 2 sh performed? death? ✔ Yes 2 ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical **Division of Vital** Be Hospital: 1 Other 4 DOA Nursing Home 5 Other: Inpatient 2 V ER/Outpatient 3 Residence 6 this 1 🗸 Yes After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death Certification: Sep 15, 2007 Subject shot 2338 hrs Natural 1 Yes 2 ✔ No Pending Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State)
1500 Block of North Woodyear Street, Baltimore, MD (Specify) Local Street 4 V Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

the Hospital or Attending Physician: 24 hours after death within 2 To the 1

> 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year)

> > SEP 2 1

29b. Signature and title of certifier

111 Penn Street, Baltimore, MD 21201 2. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 16, 2007

Registrar

2007

and manner stated

State of Maryland / Department of Health and Mental Hygiene, 30324 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Clarence Kennedy SEPTEMBER 12 2007 9:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. Mary's Hospital Leonardtown St. Mary's 8. Date of Birth (Month, Day, Yea March 13, 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 ₩ M 2 □ F 178-24-8260 77 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No Director Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21585 Peabody Street 20650 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1947 Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 ŪXNo Specify. Specify: White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter Painting Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alden Kennedy Ruth Gadd ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Kennedy - Nephew 16 Maple Lane Stafford, VA 22556 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Date permit. Pages 1 Department of H Important: If Ite any Injury or ot IX Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Calvary Cemetery 9/15/07 4 ☐ Donation 5 ☐ Other (Specify) Kennedy Twp., PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Musmanno Funeral Home 700 7th Street McKees Rocks, PA Approximate Interval Between Onset and Death Ant1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final entrich Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CAD Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed DM for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably Pynus 1 ☐ Yes 2∏ No 4 🖺 Unknown After this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe Division or Vital 2 No ospital or Attending Physician: hours after death. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH PATEL, M.D. 22650 CEDAR LANE COURT, LEONARDTOWN MARYLAND 20650 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 Registrar

DHMH 17 Rev 1/2001

KENNEDY

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CLARENCE

State of Maryland / Department of Health and Mental Hygien 9 0 0 7 1 - For State Registrar 30325 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sept. 2007 E. Krochma1 4:20am Amy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Burtonsville** Holy Cross Rehab & Nursing Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 9. Birthplace (State or Foreign 1 □ M 202 F Yrs. Director 579-30-5898 93 Washington, May 7, 1914 Usual Residence of Decedent the Maryland 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, tre Medical Eventhar must be notified at MD 1 ☐ Yes 2X No Director Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 314 Burnt Mills Avenue USA 20901 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔼 No þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7: h and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Labor Union 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jeremiah Zuckoff Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun Fred Krochmal - Son 2021 Labrador Lane Vienna, VA 22182 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State King David Memorial 09/19/2007 Falls Church, VA * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 721 Elden St. Herndon, VA 20170 Adams-Green Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ordial coordingthan /Medical Due to (or as a consequence of): Examiner isto TI4 0. SICK SIMUS Sequentially list conditions, the product of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Quality as a consequence of) Examiner The law requires that the death certificate be executed burial-transit P Due to (or as a consequence of) Records, P.O. Box 68760, attending physician Physician/Medicai the 38 use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy ō Day Month Year 4 Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Nnknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check onl. one Hospital: Other: P 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After this 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending 1 Natural death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier DECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kes 9/18/07 06054566 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14702 Theaf Jerray Silverspring BLOGAVIL 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Gerale.

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 30326 For State Registral Certificate of Death 2. Date of Death 3. Time of Death 19^{Day} , 2007^{Year} Month Sept. 21:47 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carrol1 8. Date of Birth (Month, Day, Year) Jan 24, 1922 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Birthpiace , Country) WI 1 € M 2 □ F Months Days Hours Yrs. 85 390-12-7540 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MD Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1♥1 Yes 2□No If Yes, Give Year or Dates: WW 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Warried 1 ☐ Yes 2 ☐ No Specify: Specify: White WWII 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transportation Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Karfonta Marie Fejan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Frances C. Karfaonta (wife) 7200 Third Ave A-209 Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crestlawn Mem. Gardens 9/22/2007 Marriottsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee PANGHT FUNERAL HOME & CHAPEL, PA (Box 195) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir fory arrest, shock, or heart failure. List only one cause on each line. 1400764 Sykesville, MD 21784 (410)-795-1400 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify)

Physician /Medical Examiner

Examiner use as the burial-transit

Physician

*/Medical

Examiner

Funeral

Director

or 28a-f show

or items 23a

"natural",

permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medicone.

the Medical Examiner must be notified at

Completed by Funeral Director

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

9 ☐ Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident 3 ☐ Suicide

4 Homicide

29a. Certifier

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Medical Certification

The law requires that the death certificate be executed To the Hospital or Attending Physician: To the Funeral Director: After the completely filled in by the funeral death. within 24 hours after To the Funeral Direct

Box 68760,

Division or Vital Records, P.O.

DHMH 17 Rev 1/2001

Stephen M. Smith 31. Date filed (Month, Day, Year) State Registrar

152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magnetistated. 29b. Signature and titl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be

Hospital:

9□Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

200 Memorial Avenue

1 Inpatient 2 FR/Outpatient 3 DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License numbe

Other:

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Westminster, UD 21157

26. Place of Death (Check only one,

24a. Was an

autonsy performed? 1☐ Yes 2 No

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 5 2:30 Jerome Alphonso King Sept. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bradford Oaks Nursing & Rehab Center Prince George's Clinton Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 □ F 213-24-3040 76 11/26/1930 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 ☐ No Director Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4301 Cimarron Lane 20744 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: Black ≥ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond King Blanche Bland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda V. Simms/Daughter 4301 Cimarron Lane, Ft. Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 9/11/07 Suitland, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 5538 Marlboro Pike, Forestville, Maryland 20747 Part . Briter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician tia Domen disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): sician and burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1☐ Yes 2☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a ld be detached f 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown been signature should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy performed? Yes 2 1□ Yes within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Tes Hospital: 2 ER/Outpatient 2 00 1 Inpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: or Attending (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation M 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital 1 Settifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingston Pent TANNER MY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30328 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year SEPTEMBER 20 2007 1925 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2**X**) F Months Hours 49 215-64-8912 Director July 9,1958 Maryland Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at show 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Baltimore Dundalk 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be r 450 Westfield Road 21222 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify þ 3 Widowed 4 NDivorced Specify: White Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years Manager Wal-Mart 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be 1
Department of Health and Mental I
Important: If item 27 is marked of
any Injury or other traumatic ever Frank P. Keller Kathryn Decker ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank & Kathryn Keller Parents 450 Westfield Road, Dundalk, Maryland 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21, 2007 21. Signature of Funeral Service Licenses Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease shock, or heart failure. L e, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTI SYSTEM DRGAN FAILURE Physician 4 DAYS /Medical Due to (or as a consequence of): Examiner 4 DAYS SEPTIC SHOCK Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed PYELDNEPHRITIS IWEEK burial-trar Due to (or as a consequence of) physician s the burial Box 68760 Physician/Medical attending pl IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Year Day 5 Other (specify) P.0. ed by the a 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy Division or Vital 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 27 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No after death Director: the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 5 To the Hospital within 24 hours at To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature ape title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

To the Hosp within 24 hou To the Fune Commission II

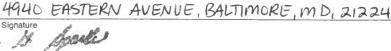
State Registrar

31. Date filed (Month, Day), Year)

SED 2. 1 2007

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



000

Day 8 David Lowe 9 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Nayland Med Ctr 8. Date of Birth (Month, Day, Year) University 0 Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sek 7. Age (In yrs. last birthday, **Funeral** Months Days 1 ★M 2 ☐ F 59 Hours 235-84-5362 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location nt of Health and Mental Hygiene.
If Item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at West Director Virginia | Jefferson Harpers Ferry 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? 32 Oakhill Court 25425 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working Disabled Diabled Diabled Elementary/Secondary (0-12) College (1-4or 5+) N/A 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Sherman Lowe Raye June Brandfass ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2605 Mission Road, Harpers Ferry, WV 25425 Cindy Armstrong/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot once. **Physician** /Medical Examiner Examiner that the death certificate be executed and Physician/Medical the as Be Completed by After this certificate has Certification: To

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 1 - For State Registrar

Physician

1. Decedent's Name (First, Middle, Last)

4 Donation 5 Other (Specifi		and Cemetery	2007 Wa	arren Coun	ty,VA		
21. Signature of Juneral Service Licer	1966	22. Name and Address of Fac					
e met ?	Sein	1062 W. Main S	treet,Berryvi	lle, VA 226	11		
shock, or heart failure. List only	plications that caused the death. Do none cause on each line.	not enter the mode of dying, such	as cardiac or respiratory arres	t,	Approximate Interval Between Onset and Death		
Immediate Cause (Final disease or condition resulting in death)	a. Endocardi			`	Onoct and Death		
Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Mital Va c. Techemic Due to (or as a consequence of	Ive Disease Bowel	2				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliments	very Day Year		
Part II. Other significant conditions o	ontributing to death but not resulting in	the underlying cause given in Par		cco use contribute to	the cause of death?		
			24a. Was an autopsy performe	24b. Were autoprior to condeath?	opsy findings available ompletion of cause of 2 ☐ No		
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	Other	ce of Death (Check only one)	ne 6 DOther (Spec	ifu)		
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. T	ime of 28c. Injury at Work? M 1 Yes 2	28d. Describe how	o Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred			
3 Suicide 6 Could not be determined	28e. Place of injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Stre City or Town,	reet and Number or Rural Route Number, , State)			
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledge niner: On the basis of examination and and manner stated.	, death occurred at the time, date d/or investigation, in my opinion, d	and place, and due to the cau leath occurred at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)		
29b. Signature and title of certifier	A	29c. License numbe	290	I. Date signed (Month	, Day, Year)		
Mena	Un grage	10N D 0000	292	9/18/20	007		
30. Name and address of person who of Jay Menaker	22 S. GV	Type, Print) reeve St., E	Baltimore,	MD ZI	201		
31. Date filed (<i>Month</i> , <i>Day</i> , <i>Year</i>) SEP 2 1 200	2. Registrar's Signature	port					
		ORIGINAL					

Please Type or Print in Black Indelible Inde. Ensure All Copies Are Legible.
Amend item#loa,perffl, 69/1,9/21/10/4, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

Month

30329

3:03PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1⊈Yes 2 No

Year

Ohio

Black, White, etc.

2007

Medical

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30330 Reg. NoZ U U 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** September 16, 2007 10:30 P.M Helen Dayton Loper /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery <u>Suburban Hospital</u> Bethesda If Under 24 Hrs 9. Birthplace (State or Foreign Country) New York 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Funeral Days Hours 1 □ M 2 🕅 F 076-38-7553 Director 108 November 18, 1898 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at N. Bethesda Maryland Montgomery Directo 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2920 any injury or other traumatic event. The Natural 20852 United States Funeral 5550 Tuckerman Lane 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 9 Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Punderson Robert (NMN) Dayton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry C. Loper / Son 11603 Split Rail Court, N. Bethesda, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Sept. Date 20, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Montgomery Crematorium, Inc. 2007 Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurg. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (First disease or condition resulting in death) Acute Pan creatitis **Physician** /Medical Due to (or as a consequence of): Examiner Gall Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Hyper natremia Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Perkalemia perform Anemia certificate 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 Impatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 0062167 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hossein Akhondi Asl, M.D., 9600 Old Georgetown Rd., Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Sept 16 2007

Helen P. Loper

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2 20 Lawson khe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ockville hady Grove Nursing home Mont gomes If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛛 F Months Days Hours Min. 236-64-8355 19, Feb. 1941 Maryland Director 66 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 SYes 2 □ No Director Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1072 Westside Drive 20878 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: þ 3 Widowed 4 Divorced White 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) is marked other than Elementary/Secondary (0-12) Contract Assistant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Thomas Rawlings Blanche McDonald 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 James H. Lawson / Husband 1072 Westside Drive, Gaithersburg, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Sept. 20, 5 1 Burial 2 □ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) Rockville, Maryland Parklawn Memorial Park 2007 21. Signature of Funeral Service License Robert A. Pumphrey funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** multiple /Medical Due to (or a a consequence of) Examiner mellit exeties Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been signed as the state of 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate ha 1∐ Yes 2 ☐ No 2**X** No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 1 | Yes 2 No 2 4. Aursing Home 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify)

Division or Vital Records, P.O. Box 68760; To the Hospital or Attending Physician: this Director: / Vithin 24 hours

Baltimore, Maryland 21215-0036

28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Natural (Month, Day Year) Injury 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifiei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

huans 0 31. Date filed (Month, Day, Year)

2007

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Month Day **Physician** BEL /Medical 4c. County of Death Ballo . C 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Éxaminer House -00 Jorning Dicle Sattle Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age 6. Sex (In vrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 ☐ M 2X F Director 01/11/1920 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d, Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Baltimore Kingsville 10f. Zin Code 10g. Citizen of What Country? 10e Street and Number death v or items 23a 7030 New Cut Road 21087 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. event, the Medical Examiner 72 hours after 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: Completed by 3 X Widowed 4 ☐ Divorced White 'natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental I Pages 1 and 2 should be traumatic ဥ Liston Bevard Katherine Dalton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 l Department of Health Important: If Item 27 any injury or other tronce. <u>Katherine R. Pietruszka (Dtr.)</u> 5698 Arnhem Road - Baltimore, Maryland 21206 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Church Cem. 09/24/2007 Hydes, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 60 11750 Belair Road - Kingsville, Maryland 21087 ass 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Wrwsclero Ses **Physician** 10acs /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner death certificate be executed resulting in death) Last Due to (or as a consequence of): nemia Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 □ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 1☐ Yes Physician: director. 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending (Month, Day 5 Pending investigation M 1 ☐ Yes 2 ☐ No death 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital within 24 hours a To the Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) charles 0701 CAPLOS E. ARANA 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

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Registrar

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92. Registrar's Signature

Dekwood

Road Glen Burnic MA

21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30334 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 18 2007 8:00PM EDWARD DULANEY LITZINGER SR. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Point Ceci VAMARYLAND
5. Social Security Number HEALTHCARE SYSTEM Herri If Under 1 Year I If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1X M 2 □ F 214-12-0210 May 3, 1922 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 624 Carsins Run Road 21001 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Training Foreman U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Edward Litzinger Rachel Virginia Pierce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 624 Carsins Run Road, Aberdeen, Maryland 21001 ace of Disposition (Name of Date 20c. Location - City or Town, State Dorothy V. Litzinger / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 SeBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) St. George's Episcopal 9-22-07 Perryman, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. of Funeral Service License 1317 Cokesbury Road, Abingdon, Maryland 21009 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause of each line. Halt1. Unter the disease, or conshock, or hear failure. List only Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) PNEUMONIA UNKNOWN Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural Injury

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

2

Completed

Be

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Funeral

Director

?7 is mark other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

"natural", or

permit. Pages 1 and 2 should be filed a Department of Health and Mertal Hygic Important: If item 27 is marked other i any Injury or other traumatic event, <u>tr</u>

Maryland 2121

Baltimore,

Box 68760

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Records,

or Vital

Division Hospital or Attending

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burial-tran physician Physician/Medical the as for ed by the 2 Completed certificate has Be P this funeral After Certification: Director:

To the within 2 To the

hours after 24 hours at re Funeral C

29b. Signature and title of certifier

6 Could not be determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VA MARY LAND HEALTH CARE System, Perry Point, MD 21902 am, Diondo

31. Date filed (Month, Day, Year) SEP21

2 Accident

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

gistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 30335 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Month Year **Physician** James Glenn Logan 2007 5:45 p. /Medical Sept 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1401 Marbeth Drive Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Months 1 → M 2 □ F Hours Yrs. Director 87 Aug. 25, 1920 West Virginia 236-20-7650 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-4 ehrer any injuy or other traumatic event, the Medical Event. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ∐Yes ≱ŢŢNo Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1309 Willow Road 21222 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician - Beth. Steel Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Crawford Logan Luella Ward 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 21222 Lewana Bowen (Daughter) 1401 Marbeth Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5 3 ☐Removal from State 5 ☐ Other (Specify) of Faith 9/20/2007 Baltimore, Maryland 21. Signature of uneral Service Licen 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Post. Enter the disease, or complications that on sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a service of the disease or complications that on sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a service of the disease or complications that on sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a service of the disease or complications that on sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a service of the disease or complications that on sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metas 4 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, isading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🔣 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Daughter's Hospital: 1 Yes 2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

The law requires that the death certificate be executed attending physician and for use as the burial-trai Division or Vital Records, P.O. Box 68760 signed by the a s certificate has t irector, page 2 s To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified I Director: After to d in by the funera

3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

one)	and manner stated
29b. Signature and title of certifi	

29c. License number D15546

29d. Date signed (Month, Day, Year) Sept 18 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Hodgett HUD 5601 Lock Raven Block Battimore MD 21239 31. Date filed (Month, Day, Year)

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 30336

naming D. My		1- For State Control of Many Maria / Department of Health and Menta		Z 0 0	, 5000
Physici		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death
ledical Exami		(banning D. Myrick	Month September	16, 2007	1659 hrs
		4a. Facility Name (if not institution_give street and number) 4b. City, Town, or Location of	Death	4c. County of Death	
		Johns Hopkins Hospital Baltimore	Calles In Date of Birth	- and Doggood G. Bis	thalana (State or
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Yea	24Hrs. 8. Date of Birth Min. 1–99-	Foreig	
		Usual Residence of Decedent	1 61	1101	110
w any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show d at once.	현	MD Baltimore	140	O'S'	
	Director	10e. Street and Number	10	g. Citizen of What Cou	ntry?
with the s 23a or c notifie	ral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	1? (Specify Yes or No-	14, Race - Amer	ican Indian, Black,
death w	Funeral	Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, F	ouerto Rican, etc.)	White, etc.	1 6
after ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Specify:	lack.
hours 'matur		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16b. Kind of Business/	Industry
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medisa	Co		Name (First, Middle, M		
121 I be fill ental F arked	Be		trea S	tern	
D 2 should and M 7 is m	P	19a. Informant's Na le/Relationshil (ype, Print) 19b. Mailing Address (Street and Number) 1520 Home St.	A	ber, City or Town, State	e, Zip Code) AAへかかかめ
a al al al		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturall", injury or other traumatic event, the Medical Examiner.		1 XBurial 2 Cremation 3 Removal from State crematory or other place	9/22/07	Pa Ha	om Mil
Baltimc permit Page Department of Important:		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. March dress of Factors	CO PAID FI	120 ml S	over ces
Pe De miii		130 Clyta M01363 4905 you	Rd. Ba	Rto MDZ	1212
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cal failure. List only one cause on each line.	diac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):			Death
		Sequentially list conditions, b.	1.2		
	iner	If any, leading to immediate Due to (or as a consequence of):			
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760, icate be executed sphysician and the burial - transit	Medical	UNPENDED AMENDED		22d Date of deliver	
876 tificat ing ph as the		FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic	pregnancy	23d. Date of deliver Month	y Day Year
Box 687 e death certific the attending p	sician/	Pregnant at time of death 5 Other (Specify)			0
b. Be the de by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	t I. 23e. Did to	bacco use contribute to	the cause of death?
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rds, requir	Completed		24a. Was a		utopsy findings available completion of cause of
SCOI ne law te has ge 2 sl	mp		perform	med? death?	
II Re Int Th rtifficar Ior, pa		25. Was case referred to medical 26.Place of Death (- 110
Vita rysicia this ce	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other 4	Nursing Home 5 1	Residence 6 Othe	er:
n of Ing Pl After funeral	n: T	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending Sep 16, 2007 1625 hrs 1 Yes 2	Subject shot	now injury occurred	
Sior Attend death. ctor:	catic	2 Accident Investigation		Name of Alicenters on D	oral Davida Niverbay Other
Division of Vital Records, tal or Attending Physician: The law requir stafter death. al Director: After this certificate has been seled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined (Specify) Street	or Town, St		ural Route Number, City
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific: within 24 hours after death. To the Finiterial Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as th		4 Memicide Section Street 29a. Certifier (Cheek only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place.)			ted.
o the l ithin 2 o the l	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occard manner stated.	urred at the time, date a	and place, and due to t	ne cause(s)
F % F %	Me	29b Signature and title of certifier 29c. License number		29d. Date signed (Mo	
		Patri (ronis-Poller a O.C.M.E.		September 17, 2	2007
"		Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Bal	timore. MD 21201	1	
	tate	31. Date filed (Month, Day, Year) 32. Regustrar's Signature			
Regis					
DHMH 17 Rev 1/2	2001	OCME ORIGINAL			

State of Maryland / Department of Health and Mental Hygiene, 30337 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Dorothy B. Mintz 2007 /Medical September 16, 9:58 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs.
Wonths Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X 1 F Director 297-07-4200 90 March 15, 1917Ohio Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified any once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 403 Russell Avenue Apt. 413 20877 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🖸 No \$ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Ralph Barker Lena Bertine Oxley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sidney Mintz/Husband 403 Russell Avenue, Apt. 413, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) Norbeck Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State September 1 Burial 2 □ Cremation 3 ☐Removal from State Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21, 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Rockville, Inc. 300 West Montgomery Avenue Rockville, MD 20850 Home/ M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PULMONARY EMBOLISM 3 MINUTES /Medical Due to (or as a consequence of): Examiner FRACTURE MONTHS Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last THE TO FOR ME IN CONSEQUENCE OF Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a 9 Unknown signed by I be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been siç , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No ပို 2 NER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Investigation LOST BALANCE - FELL TO FLOOR MARCH 21 2007 1800 1 ☐ Yes 2 ☑ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide HOME - ASBURY METHODIST VILLAGE 403 RUSSELL AVE GAITHERSBURG MD within 24 hours a To the Funeral L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19 2007 D47093 SEPTEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE MARYLAND THAI MCGREIVY MD 9901 MEDICAL CENTER DRIVE 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 17 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Year Hazel H. Morys 11:39 A M /Medical September 19, 2007 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Director 228-54-4391 Feb. 4, 1915 South Dakota Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3701 International Drive #731 20906 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No 2 Specify: White 3 ☑ Widowed 4 ☐ Divorced 'natural", Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) the Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be Harry Hof ပ Anna Whitman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy C. Walsh/Daughter 11760 Split Tree Circle, Potomac, MD 20854 If item ? 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Pages 1 20c. Location - City or Town, State September Alta Mesa Memorial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 29, 2007 Palo Alto, CA Park 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Euneral Service Licenses M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician whythmie /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi and Due to (or as a consequence of) P.O. Box 68760 attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 H Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending Iniurv 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Med Direct 0050410 Dens Ed 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Porner Philip Dr. Oly 18101 MI 111. chae 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007

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Ħ		Ţ,	1. Decedent's Name (First, Middle, La	st)					2. Date of Death		3. Time of Death
	Physici /Medi			Harry 1	Murzal	k			Septembe:	r 17, 2007	2:50PM M
	Examir		4e. Fecility Name (If not institution, give	e street and number)			4b. City, Town, or	Location of Death		4c. County of Dee	th
1	2 119			w Home				ockville			gomery
	Funeral Director		212-23-6344	ex 7. Age XM 2□ F	89	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) August 9,	9. Bir	thplece (State or Foreign ountry) New York
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				10d. fnside City Limits
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	er dez	nue	11. Marital Status	12. Was Decedent I Armed Forces?		13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Pygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinations and inject.	Completed by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 MYes 2 □ N If Yes, Give Year or Dates:	WWII		l□Yes 2X No	Specify:		Specify:	White
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ary	shou and N	Γ,	19a. Informant's Name/Relationship (19b. Mailin	g Address (Street a	and Number or Rur	al Route Number, (City or Town, State,	Zip Code)
	and 2 saith a n 27 i		Vivian E. Heven	er/ Niece	{	618 S	outh High	Street,	Harrisonb	urg, Virg	inia 22801
ore	of He of He If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Plac	e of Dispo	sition (Name of natory or other place	e) Sont	Date 20	c. Location - City or	Town, State
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Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service Licer	X /	M0033	35 B	Name and Addrese thesda—C	s of Facility Rolling Rolling Char hevy Char Maryland	bert A. P 20814-35	umphrey F 7557 Wisc 01	uneral Home/ onsin Avenue
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Vital Records,	sician: The law requires thet the death certificate be executed certificate has been signed by the attending physicien and firector, page 2 should be detached for use as the burial-transit	Completed	_ Osteonyeli	45					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
ā		ပို	25. Was case referred to medical					00.81 / 5	1 ☐ Yes 28	No 1 ☐ Yes	2 No
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DIVISION	or Attender de Directo	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home	e, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Re State)	ural Route Number,
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- 4	25+1		30. Name and address of person who	ompleted cause of de		Ba) (Type, F	Print)	entrese	RRA	9/17/07. Cockvil	le MD
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc 2871 9-21-07 vt State of Maryland 7 Department of Health and Mental Hygiene 30340 10c per fh Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9 **Physician** 4:50 am 2007 Frances V. McPherson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10015 Sweepstakes Road Damascus, MD Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) 2/22/1948 6 Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 元 F 226-70-1654 Director Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at Washington, DC Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1636 Buchanan Street, NE 20017 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☒ No Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Postal Clerk U.S. Federal Gov't. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ William Winston Lorraine Wynn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alicia Scott/Daughter 10015 Sweepstakes Road, Damascus, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once, Mt. Olivet Cemetery 9/18/07 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC 21. Signature Juneral Service Licensee 22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike, Forestville, MD 20747 23a. Part1. Enter the disease, or complications that caused the fleath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) years /Medical Due to (or as a conse mence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed bunal-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 □ Yes No. 3 Probably 4 □Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home State Nursing Home State Nursing Home State Nursing Home daughter's 1 Yes 2<u>□</u> No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital or within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 30. Name and address of person w

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Division or Vital Records, P.O. Box 6876

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 2007 30342

			1 - State Registrar	J	Ce	rtificate of	Death	Reg.	. No.	00014
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			Perring Parkwa 5. Social Security Number 6. S		ast hinthday	If Under 1 Year		8. Date of Birth		
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	h the	Director	10e. Street and Number	4.110 11 0		10f. Zip Code			Citizen of What Co	untry?
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	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heath and Mental Hygiene. If item 27 is marked other then "neturel", or items 23a or 28e-1 show or other treumatic event, the Medical Examinat must be rediffed at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1 □ Yes 21 No	Specify:		Specific	nite
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an	d be ental	э Ве	Arthur Raymond					nia Mae W		
Maryland	2 should and Men ts marke eumatic	7	19a. Informant's Name/Relationship (19b. Maili	na Address (Street	and Number or Rura			in Code)
	1 and 2 :: Health ar tem 27 is		Christopher Math	eson (Son)	1619	Four Geo	orges Cour	t Apt. B	-1 Dundal	k, MD 21222
Baltimore,	permit. Pages 1 an Department of Heali Importent: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 22☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.	Removal from State	metery, crei	osition (Name of matory or other place Service (corp. 9/20		c. Location - City or T Towson , Ma	
Balt	permit. Departr Importe any inju		21. Signature of Funeral Service Lice	Home of D	undalk, I ryland 21	nc.				
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n C	ling f	lon	27. Manner of Death 1 ☑Natural 5 ☑ Pending	(Month, Day Year)	28b. Time of Injury	Worl		28d. Describe how i	njury occurred	
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Division of	tel or A s after el Direc ed in by	Certification:	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, rarm, str)	eet, ractory, office		City or Town, S	t and Number or Ru itate)	rai Houte Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	1	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exen	ysicien: To the best of my knowniner: On the basis of examination and manner stated.	vledge, death on and/or in	n occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
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	7		30. Name and address of person who	completed cause of death (Item	23a) (Туре, Д N (Print) PW4	NUXSIN	16 HOME	PALT. M	ENTWORTH
	Sta Registra	29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and daddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature 29c. License number 29d. Date signed (Month, Day, Year) 30 Registrar's Signature 31. Date filed (Month, Day, Year) 32 Registrar's Signature 34 Certifier (Check only one) 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature 31. Date filed (Month, Day, Year)							21234	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician Month 22:33 PM 09 2001 Walter T. Maczka /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rosedale Franklin Square Hospital Center Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F (Month, Day, Year) 10/28/18 Days Hours Min. 705-12-7614 88 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Directo MD Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 406 Riverside Road 21221 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Armed Forces?
1 □XYes 2 □ No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2X Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Used Car Dealer Automotive is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walenty Maczka Alice Getka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Maczka/ Wife 406 Riverside Road Baltimore, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dundalk. MD St.Stanislaus 09/22/07 22. Name and Address of Facility 300 Mace AVenue Balto. M Connelly Funeral Home of Essex 21221 21. Signature of Funeral Service Licensee MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (unes a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No 1∐ Yes To the Hospital or Attending Physician: funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2XER/Outpatient 3 □ DOA ဥ 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 □ Yes 2 □ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

MACZKA,

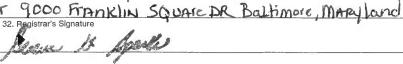
Registrar

SEP 2 1 2007

31. Date filed (Month, Day,

Schrader

Mame and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 30344 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Naomi Marner 4:50 AM september 2007 17 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A **Baltimore** Union Memorial Hospital If Under 1 Year | If Under 24 Hrs Social Security Number Date of Birth (Month, Day, Year) Mar 20, 1919 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 V E So. Carolina Director 88 219-14-2166 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic exercition." 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Baltimore Director Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21225 229 Berlin Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ WNo Specify: Black <u>ک</u> Specify: 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Muldrow Norman Muldrow ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2701 Garrison Avenue Baltimore, Maryland 21215 Louis Butler Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 DeBurial 2 ☐ Cremation 3 Removal from State 09/21/07 Marriottsville, Maryland Crestlawn Memorial Gardens 4 □ Donation 5 □ Other (Specify) f Funeral Servi Licensee 22. Name and Address of Facility 21. Sigvatur Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis 9 days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisease or irriury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autop-perform

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, certificate has t rector, page 2 s s after death.

I Director; / within 24 hours at To the Funeral Completely filled it

25. Was case referred to medical examiner? To Be 2 No 1 Tes 27. Manner of Death Medical Certification: 1 Natural
2 Accident 3 ☐ Suicide 4 Homicide

5 ☐ Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient Year!

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 Yes 2 No

29c. License number

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

26. Place of Death (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier (Check only one)

M.D.

AT 2438946

September, 17, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (201 E. University

Ma Win Nander Thyke 31. Date filed (Month, Day, Year) SEP

32 Registrar's Signature

Parkway, Baltimore, MD-21218)

State

Registrar

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year)

OCME

30. Name and address of person who completed cause of death (Item 23a)

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend it from a y lend / Berearment of Health and Mental Hygiene 30346 Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 18 **Physician** Ruth Holmes McCampbell 6:15 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore N/AIf Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 24, 19 163Se22V 3053 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🗓 F 84 California Director 1923 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at California Butte Chico 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 Sierra Lakeside Dr. 95928 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XI If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: þ Specify: 3 ☐ Widowed 4 X Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 5+ teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Henry Holmes Hazel Roxanna Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health at Important: If Item 27 Is any injury or other traus. Margaret McCampbell/daughter 1811 Dixon Rd. Baltimore, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount CrematorySep. 20,2007 Baltimroe, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc
Raltimore, MD 21212 21. Signature of Funeral Service Licensee 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Heratic Failure
Due to (as a consequence of): **Physician** tailure /Medical **Examiner** (weeks Colon Cancer Metastases Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? Yes 2 No this certificate I Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 2 No 1 ☐ Yes P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After To the Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 09/18/2007 D 41476

State Registrar

Registrar SEP 2.1

RIVINOND

30. Name and address of

31. Date filed (Month, Day, Year)

M. CMILLS H MD

2007

6763 H CHARLES ST, H416 BALTIMOZE, MD

person who completed cause of death (Item 23a) (Type, Print)

expersed 615pm

RICE MC COMPLECED

07-07321 David J. Peters Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

via J. Peters		- For State	Of Ivial yland / I		e of Death)	, 5	Reg. No.	200	37 303
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edical Exami		4a. Facility Name (if not institution, giv	e street and number)	Peter	4b. City, To	own, or Location of D			. County of Death	l
		University Hospital			Baltim				DD/YYYY) 9. Bir	thniana (State or
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r death or iten must l	Funeral	1 Never Married 2 Married	1 Yes 2	No	1 Yes 2	-t+		,	Specify:	rito
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15-0036 filed within 72 hours after death with the Maryland I Hygiene. co dother than "natural", or items 23a or 28a-f she to dother than Examiner, must be notified at once	Completed	17. Father's Name (First, Middle, Las	0		eel ux	18.Mother's	Name (First,	Middle, Maider	Surname)	Sieca
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f show any event, the Medical Examiner must be notified at once.	Be C	Goldon	- //:	rs. S	R.	Lix	slove	s Ble	ach_	a Zin Codo)
hound N is n	유	19a. Informant's Name/Relationship (Type, Print)	19b	38 Mei	Street and umb	/ / / /	oute Number, C	Sity or Town, Stat	e, 21p Code)
re, MD 2 s I and 2 shou of Health and P If item 27 is ner		20a. Method of Disposition	Wite		Disposition (Narry or other place	ne of cemetery,	Date	20c.	Location - City o	r Town, State
more Pages I ent of F int: If i		1 Burial 2 Cremation 3 4 Donation 5 Other Specific		Funsfi	incial Che	isel-Belfin	9/26	107 FC	rest Hil	(MD
Baltimore, permit. Pages 1 a Department of He Important: If it in injury or other t		21. Signature of Funeral Service Lice	nsee	T THE COLOR	22. Name and	Aldress of Facility	1000	portion	, Forest	111, MD 2105
Physician	<u> </u>	23a. Part I. Enter the disease, or con	plications that caused t	he death. Do no	t enter the mode	of dying, such as car	diac or respi	ratory arrest, sh	nock, or heart	Approximate Interv Between Onset an
Medica	1	failure. List only one cause of	each line. U Multiple Injuries							Death
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60, ate be exchysician	Medical	UNPENDED	AMENDED 23c. If yes, outcom	ne of pregnancy					3d. Date of delive	ery
3876 rrtificate ling phy	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live birth	2			pregnancy		Month	Day Year
Box 687; death certific	Physician/	1 Yes 2 No 9 Unknow		time of death	Other (Spe	ecify)				
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Iling Ph	on: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Day Y Sep 19, 2007		Time of Injury O hrs	28c. Injury at Work	Mot	Describe how orcycle driv	er in collision	with truck
Sior	icati	Natural 5 Pending 2 Accident Investig	ation 28e Place of in	ı	arm, street, factor	ry, office building, etc	28f.			Rural Route Number, C
DIVI	Certification:	3 Suicide 6 Could n 4 Homicide	ned (Specify) Ma	jor Road / H	ighway		Rou		oute 462, Abero	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Functor: After this certificate has been signed by the attending physician and the final after this former property or so a chold be detached for the step the hind.	cal C		ician: To the best of m	y knowledge, de	ath occurred at thinvestigation, in r	ne time, date and pla ny opinion, death occ	ce, and due curred at the	to the cause(s) time, date and	and manner as s place, and due to	tated. the cause(s)
To th withir To th	Medical	29b. Signature and title of certifier	and manner stated.			9c. License number				Month, Day, Year)
		4	/ has			O.C.M.E.		S	eptember 20	, 2007
		30. Name and address of person wh	_	death (Item 23a)	Penn Street	Baltimore, MD 2	21201	•		
je			nief Medical Exam	ar's Signature	.0	Dalumore, WD 2	- 1201			
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		For		State o	of Marylar					d Mental Hy	/gien	e	
		1 - State Registrar				Ce	rtificate	of D	eath		Reg. No	2007	30348
Physici	an	1. Decedent's Name	(First, Middle, Las JOSEPHI	,	C III A					2. Date of D Month	Da		
/Medic		4a. Facility Name (If					4h City To	wn orl	ocation of De	SEPTEM		17 20 c. County of De	
Examir	ier	/ /	AMARITA		SOITAL		7	_	10	aui		. County of De	atti
Funeral	77	5. Social Security No	umber 6. Se	x	7. Age (In yrs.	last birthday)	If Under 1 Months [- /	If Under 24 H Hours Mi		rth	9. Bi	rthplace (State or Foreign
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and and		Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
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item	H	20a. Method of Dispe	osition			Place of Dispo	sition (Name	of er place	,	Date		ocation - City o	
Page nent ant: If ury o			ĞCremation 3 □I 5 □ Other (<i>Specify</i>)		State Eva	Place of Dispo cemetery, crei ns Funer mation S	al Chap ervices	el Ar	d Sept	20,2007	Fo	rest Hi	11, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	neral Service Licens	see	. /	22	2. Name and	Address	of Facility	per, 3 N		ort Driv	
<u></u>		Condu	al hy	12 for	doll		ANS FU					Hill,	Maryland
	w s	23a. Part1, Enter th shock, or hear Immediate Cause (F				h. Do not ent	er the mode o	of dying,	such as card	iac or respiratory a	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)		u	EPSIS (or as a conseq								UNKHOWN
Examiner			iii ii		NEU M								NKNOWN
D #	ner	Sequentially list con if any, leading to impose.	nditions, mediate		(or as a conseq								0.010100010
ecuter	Examiner	Cause (Disease or in that initiated events resulting in death) La	njurý	v	HANGE		MEN	ITA	LS	TATUS			
cate be executed physician and the burial-transit		resulting in death, an		Due to	(or as a conseq	uence of):							
cate phys	edical			d									,
The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent	pregnant		tcome pf pregna							23d. Date of de	elivery
death	sicia	in the past 12 r 1 ☐ Yes 2 ☑	months?	4□Pregr	oirth 2 ☐ Feta nant at time of c		Ectopic preg Other <i>(speci</i>					Month	Day Year
at the de	Phys	9 ☐ Unknown		9∐Unkn									
res that signed t	by	Part II. Other signific		ntributing to di		ulting in the ur			in Part I.				to the cause of death?
w requires been signe should be	Completed						PATE)	7			Yes 2		Probably 4 □Unknown
he law has ge 2 g	ш			NAL	DISE	ASE				- 24a. Was	an psy ormed?	24b. Were a prior to death?	utopsy findings available completion of cause of
sician: The l certificate ha rector, page		A NEMIA 25. Was case referre						,	Of Place of D	1 Yes	2 🔀 No	1 ☐Ye	s 2□No
Physicia this cerral direct	o Be	examiner? 1 ☐ Yes 2 📉 N	11	Hospital: 1 域	Inpatient 2 🗆	ER/Outpatien	t 3 DOA	Other:		eath (Check only only only only only only only only		6 ∏Other (So	acity)
ding Ph After th funeral	Ľ:	27. Manner of Death	5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c.	. Injury a Work?		28d. Describe			sony)
tendi eath. tor: A the fu	catic	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be				M	1 □ Ye	es 2 No				
pital or Atten	Certification:	4 ☐ Homicide	determined	28e. Place buildi	of injury - At hong, etc. (Specif	ome, farm, stre	eet, factory, o	ffice		28f. Location (City or To	Street ar wn, State	nd Number or F e)	lural Route Number,
spital lours neral / filled	<u>a</u>	29a. Certifier	1 Certifying Phy	sician: To the	best of my kno	wledge, death	occurred at	the time	, date and pla	ice, and due to the	cause(s) and manner a	s stated
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical	(Check only one)	2 Medical Exam	ner: On the b	asis of examina ner stated.	ition and/or in	vestigation, in	my opi	nion, death oc	curred at the time	date an	d place, and du	e to the cause(s)
To the Vithin Com	Ž	29b. Signature and t	title of certifier	\mathcal{A}	11 2		29c. L	icense r	number		29d. Da	te signed (Mon	th, Day, Year)
		P	(0-	+	M.D		R	esi	000		0	9/17/2	007
3		30. Name and addre	ess of person who co	ompleted caus	e of death (Item	1 23a) (Type, I	Print)	2	2/8-11	n> = := :	79	1	
Sta	te	31. Date filed (Month	h, Day, Year)	32. R	egistrar's Signa	iture	DCND	DA	LIU, I	10 212-	5/_		
Registra	ar	30. Name and addre SHAMS 31. Date filed (Month SEP	2 1 2007	Alone	as the	A TOWN	English Control						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30349 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day, th **Physician** Month Year 1:36 PM reterson lohn Settember rabbo 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 X M 2 □ F Director 284-14-6335 September 24,1921 Ohio Usual Residence of Decedent 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits 23a or 28a-f show must be notified at 1 MYes 2 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Russell Aveneu, #216 20877 United States Funeral death items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Mayes 2 No 1942— If Yes, Give Year or Dates: 1946 1 ☐ Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) International than Elementary/Secondary (0-12) College (1-4or 5+) the Business Machines Marketing 7 Is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental H John A. Peterson Floye Crabbe ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Evelyn M. Peterson / WIfe 415 Russell Avenue, #216, Gaithersburg, Maryland 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State September 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 20, 2007 4 Donation 5 Other (Specify) Bethesda, Maryland 21. Signature of Funding Service Ucensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Malate Supris 23a. Parti. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Jause (Final disease or condition resulting in death)

a. District Modern Fig. 1981. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Approximate Interval Between Onset and Death Physician Due to (or a consequence f): /Medical Examiner Sequentially list conditions, cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death signed by the a 5 Other (specify) 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 MUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? 2 M No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To after death.

I Director: After this d in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year) SEP 2 1 2007

9901

32. Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Nidhi Singh Nikhanj,

Center

signature

Registrar

D0064560

Rockville

September 16th, 2007

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Katie Ruth Pierson 13 2007 10:30 PM September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11504 Basswood Court Laurel Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 7, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 20XF 89 1918 Director 410-16-4749 Tennessee Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1√TYes 2□No Director Los Angeles CA Los Angeles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 90016 USA 2738 South Cochran Avenue Funeral Pages 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 'natural', or 1 ∐ Yes 2 🛛 No Specify. Specify: Black ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Secondary (0-12) College (1-4or 5+) Medical 12th 2 Nurse is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Erma Carter Moses E. Smith ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i other tra 11504 Basswood Court, Laurel, MD Ouentis Amanda Scott 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if itel
any injury or ott
once. 1 Burial 2 Cremation XXRemoval from State Holy Cross Cemetery 09/25/2007 Culver City, California 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Dcnaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee anuo o A M01103 313 Talbott Avenue, Laurel, MD 23a. Part1. Enjecthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Septic Shock disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Energy to continue Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Parkinsons Disease 1 🔲 Yes 2√ No 3 Probably 4 Unknown Left Foot Gangrene 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an has autopsy perform certificate has rector, page 2 Infected Decubitus Ulcer 2 X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Niece's Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Injury 1 Natural 5 ☐ Pending To the nospinal within 24 hours after death.

To the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Hospitai 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D620063 September 14, 2007 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jenel Wyatt, MD 14207 Park Center Drive, Suite 102 Laurel, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 2

32. Registar's Signature

20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND, ITEM#26, per PHYS. G871, 9/21/07 WS
State of Maryland *Department of Health and Mental Hygiene 2007 State Registrar Amend 19a, per Inf. 0872, 10/9 /07 TTCertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year MALCOLM DUDLEY PHILLIPS SEPTEMBER 14, 2007 /Medical 8:56 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 308 L Willrich Circle Forest Hill Harford If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☑ M 2 ☐ F Director 202-01-8513 86 Mar. 9, 1921 South Dakota Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits giene. or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Florida Lee Fort Myers 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 12464 Kelly Sands Way
. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Completed by Funeral USA 14. Race - American Indian, 33908 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Physician / Owner/Operator | Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event once. Be Jay Malcolm Phillips <u> Irma (nmn) Dudley</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Phillips Wife 308 L Willrich Circle, Forest Hill, Maryland 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Darlington Cemetery 9-17-07 Darlington, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. Russell Slig 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEARL Physician -OUGERURE tai was five years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 2□ No Division or Vital To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) and Other: 4 Nursing Home Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Other (Specify) Residence 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1)0056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Dr., Bel Air, MD 21014 Jason Birnbaum 32 Registrar's Signature 31. Date filed (Month, Day, Year) SEP 2 1 2007 Registrar

DHMH 17 Rev 1/2001

			State of Maryland / E	epa <i>Cer</i>	artment of H tificate of L	ealth a Death	ind Mental		ene2007	30352
	Physici		Decedent's Name (First, Middle, Last) Ervin Phillips				2. Date of Month		Day Year 30 2007	3. Time of Death 2:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 3350 Curtis Drive		4b. City, Town, or Suitlar	ıd	f Death		4c. County of Dea	eorge's
*	Funeral Director		5. Social Security Number 577-62-4293 Usual Residence of Decedent	thday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Mont.	h, Day, Y	ear) C	thplace (State or Foreign ountry) shington, DC
:	sa-f show	Director	10a. State 10b. County 10c. City, Town		cation and					10d. Inside City Limits 1 X Yes 2 □ No
3	23a or 2	al Dire	3350 Curtis Drive #204		10f. Zip Code 20746			10g	United	
000	ours aner des ral", or Items Examiner m	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specity Cuba I □ Yes 2🎇 No	spanic Orig n, Mexican Specify:	gin? (Specify Yes o , Puerto Rican, etc	or No- c.)	14. Race - Ame Black, Whi	te, etc.
0-0121	d within 72 h giene. er than "natu , the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. E	lent's Usual Occupa kind of work done of DO NOT use retired stal Worl	luring most)	of working	16	Sb. Kind of Business Governmen	•
be file dot H	To Be Co	17. Father's Name (First, Middle, Last) George Phillips			18. Mothe	r's Name <i>(First, M.</i> ola Smith	1	iden Surname)		
								City or Town, State,		
	the rages in the rant: If item		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mary1	ry, cřen .and	sition (Name of natory or other place. Veterans	5	Date 9/7/2007	Ch		Maryland
Da	Depar Impor		21. Sign the of Funeral Service lice see 23a. Part 1. Enter the disease, or complications that caused the death. Do n	55	38 Marlbo	oro P	ike, Fore	stvi		yland 20747 Approximate Interval Between
E	Physician and bulking and bulking and the prival-transit the prival-transit	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, heading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Nasopharyngeal Due to (or as a consequence of the perfect of the per	of):	cinoma					Onset and Death
O. DOA O	the attending point of the control o	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)				23d. Date of de Month	llivery Day Year
. L (SD	quires triat. en signed by uld be detac	þ	Part II. Other significant conditions contributing to death but not resulting in Dyslipidemia	the un	nderlying cause give	en in Part I.		Did toba		o the cause of death?
יי ויי	cate has been page 2 sho	Completed						Was an autopsy performe (es 2	prior to	utopsy findings available completion of cause of s 2 □ No
To the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	The happing to Amenium Privacian. The law requires that the beam centure that the beam centure that the forms after death. To the Furbarial Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be		Time of njury	28c. Injury Work M 1 🔲	er: 4 🗆 Nu	28d. Desc	Residence	ce 6 Other (Speinjury occurred	
2	within 24 hours after death. To the Funeral Director: K completely filled in by the fi	al Certif	4 Homicide determined building, etc. (Specify) 29a. Certifier 1 A Certifying Physician: To the best of my knowledge	e, death	n occurred at the tin		City o	or Town,	se(s) and manner a	s stated.
	within 24 1 To the Fu completel:	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated. 29b. Signature and title of certifier	a/or inv	29c. License	number	tn occurred at the	29d	e and place, and du 1. Date signed (Mon 9	th, Day, Year)
4	5		30. Name and address of person who completed cause of death (Item 23a) (Piotr L. Grojec, M.D. 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature		Print) 6400 Distr	Mar1b	oro Pike eights, l		land 2074	
	Sta Registr		SFP 2. 1 2007	As	carti					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Arland C. Perry : 4.5M 200-/Medical 4b. City Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Sinai Hospital 301 Himore Bactimore N/A 64 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs 6. SAY Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 □ F Director 237-54-5265 No. Carolina Nov 17, 1938 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ner must be notified at 1 XYes 2 No Director N/A **Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 4013 Glen Avenue items 23a 21215 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status PERRY, ARLAND Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1965 1 ☐ Yes 2 ☐ No þ Specify: Black 3 Widowed 4 Divorced 1968 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **UPS** and Mental Hygiene. the Mail Carrier tem 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph W. Perry Jolle Perry မ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Natalie Perry Wife 4013 Glen Avenue Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/24/07 Owings Mills, Md. 5 Other (Specify) Garrison Forest Veterans Cemetery 21. Signature of Juneral Service Licens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md. 21217 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition -Un9 Physician Cance resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending phy IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day signed by the a 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did topacco use contribute to the cause of death? Medical Certification: To Be Completed by 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy page perform funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, or Attending Physician: within 24 hours after deat To the Funeral Director in by t filled To the Hospital completely

> State Registrar

(Check only

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

HOSPITAL OF BOLH more, 2401 W. Belvedeve AVI, BOLH more MD KOTEVIND. Singi

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9 **Physician** ILVIM 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Center Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 🗆 M Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify δ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important; If item 27 is marked other than any Injury or other traumatic event the servent of the ser Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Na ne (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) (Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on the line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) een **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a compequence of: Examine certificate be executed burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending p IF FEMALE: If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Feta! death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Day Yea 4□Pregnant at time of death 5 Other (specify) Records, P.O. the 9 Unknown 9 Unknow ģ Part II. Other significant conditions contributing to d 23e. Did tobacco use contribute to the cause of death? ath but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy certificate perform or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ို 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manny stated. ed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 00.55 AM **Physician** SEP 3 2007 obinsc /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner LEVINDALE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours Min. 1 🗆 M Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Kyes 2 No Director mor 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Informant's Name/Relationship (Type. Print) Important: If Item 27 is r. any Injury or other france. 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State 21. Signature of Funeral Service Licenses Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BREAST CANCER **Physician** /Medical Due to (or as a consequence of) Examiner UTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown ALLURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3□ DOA 1 ☐ Yes 2 No 2 ER/Outpatient 28d. Describe how injury occurred Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined

The law requires that the death certificate be executed Division or Vital Records, P.O.

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Baltimore, Maryland 21215-0036

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ate has bage 2 s ours after death. within 24 hours a

To the Funeral I

completely filled

State

Registrar

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number 20063327 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H- WOLDEHINGT

and manner stated.

WOLDEHHWOT, 2434 WEST BEWEDERE AVE, BALTIMORE, MD 21215

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day,

3 Suicide

29a. Certifier (Check only one)

4 Homicide



State of Maryland / Department of Health and Mental Hygien 2007 30356 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Bernard A. Ramundo September 18, 2007 10:55 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Lutheran Home Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 12, 1925 9. Birthplace (State or Foreign Country)
New York 6. Sax **Funeral** 7. Age (In yrs. last birthday) Days Hours 1X7M 2□ F Yrs. Director 073-14-2672 82 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-f ahow the Medical Exeminer must be notified at 1 Yes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7803 Fox Gate Court 20817 United States death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes 2 □ NO If Yes, Give 1972 Year or Dates: 1972 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Deportment of Health and Mental Hygiene.

Important: If then 27 is merked other than "natural, or the Important own, the Marital Exercice any follory or other traumatic event, the Marital Exercice. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: δ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Officer/Lawyer U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surrame) Be Domenick J. Ramundo Marie Spaziante 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oneida Luciano-Ramundo/Wife 7803 Fox Gate Court, Bethesda, Maryland 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State Sept. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland 2007 4 Donation 5 Other (Specify) 21. Signature of Funeral Serv e Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Ave., Bethesda, MD 20814-3501 M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBRO VASCULAL ACCE DENT /Medical Due to (or as a consequence of): Examiner INTER VENTRICULAR HE MORRHANG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of physicien and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed ALZHEINERS
Due to (or as a consequence of): DEMENTIA Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 ☑ No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No his 2 RVOutpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending thours after death.

Funerel Director: After ally filled in by the fun М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check units one) ro the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 71.0 Mherly Duy DO051158 18 SEPTEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKUILLE MD 20850 AWTHO MY 9801 VEIRS DRIVE 31. Date filed (Month, Day, Year) SEP 2 1 2007 32. Registrar's Signature State 2 Registrar COL

			State of Maryland / Der 1 = State Registrar Amend Item 26 per verb., g871,096	partment of Health and M 3-Mate of Death	ntal Hygier Reg.	2007 30357		
	Physici	an	1. Decedent's Name (First, Middle, Last) Catherine Jeannette Rehmert		2. Date of Death	3. Time of Death		
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	T	2 2007 60 A M 4c. County of Death		
1			10224 Bristol Channel	Ellicott City	, I	Howard		
ì	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 216-36-8136 1 M 2 7 F 68 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Jun. 2, 1	9. Birthplace (State or Foreign Country) Maryland		
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	with th	Dire	72 Colony Hill Court, Apt. 3B	10f. Zip Code 21227	10g.	Citizen of What Country? United States		
	death	Funeral Director		3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.		
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Baltimore, Maryland 21215-0036	ould be filed Mental Hygi arked other atic event, ti	To Be Co	17. Father's Name (First, Middle, Last) Joseph M. Rehmert		e (First, Middle, Maid	den Surname)		
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nor	ages ent of h		Tix Burial 2 Cremation 3 Hemoval from State	rematory or other place)		Location - City or Town, State		
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68760,	icate be executed physician and the burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of):					
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Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 4 ☐ Homicide investigation 5 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	M 1 □ Yes 2 □ No street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)		
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5-0036 led within 72 Hygiene. other than other Medical		7		Electri	lcal Wi				Manufacturer	
filed I Hyg	ပိ	17. Father's Name (First, Middle, Las Winfield (nmn)	·				lame (First, Middle, e (nmn) H			
ID 21215-0036 should be filed within 72 and Méntal Hygiene. 7 is marked other than natic event, the Medical	To Be	19a. Informant's Name/Relationship (Contract to the contract to th	19b. Mailing	Address (St			mber, City or Town, Stat	e. Zip Code)	
nore, MD 2121 ages 1 and 2 should be find of Health and Mental tt: If item 27 is marked other traumatic event.		Patricia L. Coll	etta/Daughter	411	ll Pros	pect Rd	., Whitef	ord, Maryla	and 21160	
Fe, I and I Health		20a. Method of Disposition		Place of Disposi crematory or oth		cemetery,	Date	20c. Location - City o	r Town, State	
Baltimore, MD 21215-0036 permit: Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Modula Hygiers in 22 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation 3 4 Donation 5 Other Specific		el Air N		1 Gdn	9-22-07	Bel Air,	Maryland	
Balti Sermit Separty Imports njury o	-	1. Signature of Funeral Service Lice		22 N	ame and Addre	ess of Facility	Home D	Δ	note II	
		22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Marylan 23a. Par(I. Enter the disease, or complications that caused the geath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart App								
Physician /Medical		failure List only one cause on each line.								
xaminer		Immediate Cause (Final disease and neck injuries complicating atherosclerotic cardiovascular disease Due to (or as a consequence of): Death Due to (or as a consequence of):								
		Sequentially list conditions,		01).		,	P			
	ner	if any, leading to immediate								
Ţ	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
cuted and transi		d								
760, icate be executed physician and the burial - transi	Medical	UNPENDED	AMENDED							
		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre			2		23d. Date of delive	<i>'</i>	
ox 68 eath certifi attending for use as I	Physician	past 12 months?	1 Live birth 4 Pregnant at time of c	anth =	al death ner (Specify)	3Ectopic pr	egnancy	Month	Day Year	
Box e death c the attented for us	hysi	1 Yes 2 No 9 Unknow	n g Unknown							
P.O. s that the gned by e detach	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?		
S, P.C uires that n signed Id be deta								1 Yes 2 No 3 Probably 4		
Records, The law require	Completed					auto	24a. Was an autopsy prior to completion of cause of			
Rec The Is	등	performed? death? 1 🗸 Yes 2 No 1 🗸 Yes 2 No 1								
tal Recian: The	Be (25. Was case referred to medical examiner?	Hospital:	-		ce of Death (Ch				
of Vital ng Physician: After this certi	은	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatient 28b. Time of Ir		Other ₄ N	ursing Home 5	Residence 6 Other	er: Scene	
nn of nding Pl h. : After e funera	.ii	1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) FOUND:	FOUND:	′ · _	Yes 2 ✓ No	Subject fel			
Division Inloratedia or Attendia or Attendia or Attendia or a free death.	icat	2 🗸 Accident Investiga	28e Place of Injury - At	1453 hrs				(Street and Number or R	ural Route Number. City	
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certiff and an after death. Funeral Director: A feet this certificate has been signed by the attending lely filled in by the funeral director, page 2 should be detached for use as	Certification:	3 Suicide 6 Could not be determined (Specify) Single Family					or Town,	28f. Location (Street and Number or Rural Route Number, City or Town, State) 106 W. Ring Factory Road, Bel Air, MD		
Hosp 24 hou Fune reely fi		4 Homicide Single Family Flow W. King Factory Road, Bet All, MiD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
Sep 18, 2007 1453 hrs 2 Accident 3 Suicide 4 Homicide 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.							e and place, and due to t	he cause(s)		
	ž	29b. Signature and title of certifier 29c. License number					29d. Date signed (Month, Day, Year)			
7		Calle	111.		0.0	C.M.E.		September 19,	2007	
100		30. Name and address of person who			Street B	altimore, MD	21201			
	ate	-	istant Medical Examine 3 Registrar's Signa		Juleet, Da	arminore, MD				
Regis	rar	31. Date filed (Meath Day, Year) 20	07 Kelver L	Apou	W					

State of Maryland / Department of Health and Mental Hygiene 007 30359 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year 00 17,2007 Дм Rutkowski (nmn) /Medical September 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death (a) If Under 1 Year | If Under 24 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🖫 F Days Yrs. Director 218-01-0203 86 29, 1920 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location ahow 10d. Inside City Limits item 27 ie marked other than "natural", or Iteme 23a or 28a-f ehov other traumatic event, Itte Madical Expenient must be notified at 1 ☐ Yes 2 XNo Direct Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 236 Bynum Ridge Road **USA** death Funeral 21050 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√2 No δ Specify 3 Widowed 4 □ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil ment of Health and Mental H lent: If item 27 le marked ott Be Teofil (nmn) Binkowski Agnes (nmn) (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Importent: If item 27 te any Injury or other trau Irene Rogers / Daughter 236 Bynum Ridge Rd., Forest Hill, Maryland 21050 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 9-20-07 Baltimore, MD 21. Signature of Funeral Service McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that clust shock, or heart failure. List only one cause of each d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Intanctia /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Years Examiner death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.0. 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ Completed 1 Yes 2 No 3 Probably 4 □Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? this certificate Division of Vital 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO ၉ 1 🗌 Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t Certification: 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 nmn McChre Phail 31. Date filed (Month, Day, Year) State 32 Registrar's Signature Registrar

Ruthowsk

Mary

Physici /Medic Examin	al
Funeral Director	Ž
yland now at	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shany injury or other traumatic event, the Medical Examiner must be notified a once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760, *\int To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

	1 - State Registrar	Certificate of Death Reg. No. 2007 303					7 30360			
	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month Day Year 3. Time of Death				
ian ical	Earl L. Ra	ivel			Sept.	16, 2007	10:00AM			
ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of De		4c. County of De	eath			
	638 Aldworth Road		D	undalk		Ba	ltimore Co.			
1	5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 F		th 9. E	Birthplace (State or Foreign			
	216-20-9909 1录M 2□F 81	Yrs.	World's Days	Hours M	May 7		Country) Marvland			
1	Usual Residence of Decedent 10a. State 10b. County 10c. Ci									
<u>_</u>		10c. City, Town or Location					10d. Inside City Limits			
Scto	Maryland Baltimore			Dun	dalk	k 1 □Yes 2₹3₹No				
Ę	10e. Street and Number	10f. Zip Code				10g. Citizen of What	Country?			
ra	638 Aldworth Road	21222				United St	tates			
nue	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	er in U.S. 13. Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Ric				14. Race - Ar Black, W	merican Indian, hite, etc.			
Ϋ́	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW	WW II 1□Yes 2□XNo Specify:				Specify: W.				
교 교	Teal of Dates.		death there is a							
ete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup- kind of work done of	during most of v	vorking	16b. Kind of Busines	ss/Industry			
Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4or 5+) 9 years	Machinist-Tool & Dye				Manufacturing				
ပို	17. Father's Name (First, Middle, Last)	rideri.	111150 100			Maiden Surname)	ur ing			
To Be	George F. Raivel				Walters	maraon camamo,				
F	19a. Informant's Name/Relationship (Type, Print)	19b Mailin	n Address (Street			er, City or Town, State	Zin Code)			
	Magdalene M. Raivel (Wife)		Aldworth							
1	20a. Method of Disposition 20b. F	Place of Dispos	sition (Name of	1	Date Date	Maryland 2.				
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cren	natory or other plac of Faith	·	9/2007	Baltimore				
	4 Denation 5 Other (Specify) 21. Signature of Funeral Service Licensee		. Name and Addres		9/2007	Bartriiore	, Maryranu			
	hally and	I	Duda-Ruck	Funera	1 Home of	Dundalk,	Inc.			
	23a Part1 Enter the disease or complications that caused the deat	h Do not ente	7922 Wise	Avenue	Dundall	. Maryland				
	23a. Part1. Enter the disease, or complications that caus. If the deat shock, or heart failure. List only one cause on each line.	II. DO NOT CITE	. 83		lac or respiratory at	riest,	Approximate Interval Between Onset and Death			
11	disease or condition resulting in death) a. Find Stage nend disease 6 months									
	Due to (or as a cookeq	uence of):								
ē	Sequentially list conditions, if any, leading to immediate b Due to (or as a conseq	uence of):								
nin	cause. Enter Underlying Cause (Disease or injury	Cause. Chief Underlying Cause (Disease or injury that initiated events C								
Xai	resulting in death) Last C. Due to (or as a conseq	uence of):								
a										
Medical Examiner	u									
	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregna	ancy				23d Date of a	deliven			
icia	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No		Ectopic pregnancy Other <i>(specify)</i>			Month	23d. Date of delivery Month Day Year			
Completed by Physician	9 ☐ Unknown 9 ☐ Unknown									
y P	Part II. Other significant conditions contributing to death but not resi	ulting in the un	derlying cause give	n in Part I.	23e. Did to	bacco use contribute	to the cause of death?			
d b					1 0 1	/es 2 No 3 □	Probably 4 □Unknown			
lete					24a. Was	an 24h Were	autonsy findings available			
E C					- autop perfo	rmed? / death	autopsy findings available o completion of cause of ?			
C	25. Was case referred to medical			26 Place of D	1 Yes	2 → No 1 □ Ye	es 2 No			
To Be	examiner?	ER/Outpatient	t 3□ DOA Othe		eath (Check only o					
<u>-</u>	27. Manne of Death 28a. Date of Injury	28b. Time of	28c. Injury Work			lence 6 Other (Sp now injury occurred	pecify)			
ī	1 ■ Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury		? ∕es 2∐No		, , , , , , , , , , , , , , , , , , , ,				
fice	3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At ho	At home, farm, street, factory office 28			28f. Location (S	Bf. Location (Street and Number or Rural Route Number,				
ert	4 Homicide determined building, etc. (Specify)									
ja	29a. Certifier 1 Certifying Physician: To the best of my kno	ce, and due to the	and due to the cause(s) and manner as stated.							
Medical Certification:	(Check only one) 2 ☐ Medical Examiner: On the basis of examina and manner stated.	date and place, and d	ue to the cause(s)							
29b. Signature and title of certifier 29c. License number 29c.							29d. Date signed (Month, Day, Year)			
much land planter										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mur Scolow My 120 Sixty Pierre Drive #105 Puson MB 2/204										
te	31. Date filed (Month, Day, Year) 32. Registrar's Signa									
ar	SEP 2 1 2007 Agree 15	Mary								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30361 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 3:00 P /Medical Fdna G. Scott 09/18/2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Old Court Center Baltimore Randallstown 8. Date of Birth (Month, Day, Year) 07/10/1930 Social Security Number . Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖫 F Vrs Director 202-20-9756 77 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 1 No Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1223 Stamford Road 21207 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 21 No Specify. 9 Specify: Black 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Item 27 is marked other the Medical Nursing Assistant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Boller Thomasina Fraizer ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha A. Johnson/ Goddaughter 1223 Stamford Road, Baltimore, Maryland 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/22/2007 Arbutus Mem. Cemetery Baltimore, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service License 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** My0 (0-01)21 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Mellitus and Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical the IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ U WOULS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unikhown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No mcule-24a. Was an las | autopsy performe certificate Vital 2 director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division or 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: stely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 To the 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 200 20 9a ~ 1006143°

State Registrar ADETEMISI

31. Date filed (Month, Day, Year)

SEP 2 I 2007

DHMH 17 Rev 1/2001

5311 OLD COURT ROAD, RANDALLS TOWN MD 21132

 $\omega_{\mathcal{D}}$

2. Registrar's Signature

30. Name and address of person who simpleted cause of death (Item 23a) (Type, Print)

SOSANTA

			State of Maryland / De State of Maryland / De Phy G871 9/24/07	partment ο e rti ficate α	of Health and Foot Death	Mental Hy	giene Reg. No 2 () (7	30362
	Physici /Medic		1. Decedent's Name <i>(First, Middl</i> e, <i>Last)</i> Martin William St	ewart, J	r.	2. Date of Dea Month Septemb		Year OO7	3. Time of Death 8:30 A. M
	Examir		4a. Facility Name (If not institution, give street and number) 27 Bon Air Avenue		in, or Location of De		4c. County of Death Anne Arundel		
ì	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthde $215\ 40\ 6009$ $1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ $	Months Da	ear If Under 24 H ays Hours Mi	n. (Month, Da		Coun	lace (State or Foreign stry) vland
	ne Maryland 8a-f show otified at	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland Anne Arundel Baltin	nore					0d. Inside City Limits 1 ☐ Yes 2 🖾 No
	th with the 23a or 2 ast be no	al Dir	10e. Street and Number 27 Bon Air Avenue	10f. Zip Coo	de 21225		10g. Citizen of W U.S.		try?
0036	be filed within 72 hours after death with the Maryland tial Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 Married If Yes, Give Year or Dates:	3. Was Decedent If Yes, specify (1 ☐ Yes 2 🕱	of Hispanic Origin? Cuban, Mexican, Pu No Specify:	(Specify Yes or No- erto Rican, etc.)		, White,	
0-6121	within 72 ho ene. than "natur he Medical I	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Oc ve kind of work do b. DO NOT use re rsone11	one during most of w etired)	vorking	16b. Kind of Bus		Resources
land 2	0 = 0 9	To Be Co	17. Father's Name (First, Middle, Last) James Joseph Stewart			ame <i>(First, Middle,</i> ena Kiley	Maiden Surname	·)	
Mary	nd 2 shoualth and M 27 is mai	-		illing Address <i>(Str</i>	reet and Number or Avenue	Rural Route Numbe Baltimor			
altimore,	permit. Pages 1 and 2 should by Department of Health and Ments Important: If Item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 Burial 2 Termation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Discemetery, or Bayview	position (Name of rematory or other Cremato		Date 20/2007	20c. Location - C Baltimor		
Dall	permit. Departm Importal any inju		21. Signature of Funeral Service Licensee	22. Name and Ad	ddress of Facility (Gonce Fun Way Balt			
D.	Physician / / / / / / / / / / / / / / / / / / /	I Examiner	23a. P.rt1. Enter the disease, or complications that caused the death. Do not ease shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C	nter the mode of	dying, such as card	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death 5 M 0 Mflu
P.O. DOX 06/00	The law requires that the death certificate ite has been signed by the attending physioage 2 should be detached for use as the	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	B⊟Ectopic pregna	()		23d. Date Mon	th	Day Year
ecords,	equires then signed ould be d	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause	given in Part I.	23e. Did to			e cause of death? ably 4 □Unknown
	sician: The law r certificate has be lirector, page 2 sh	Completed					sy pr med? de	ior to con eath?	psy findings available npletion of cause of
_ <u> </u>	nysician iis certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	ent 3 DOA	O41	eath <i>(Check only of</i>		(Specify	<i>(</i>)
VISION OF	nding Pt th. r: After th e funeral		27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year) 2 Accident investigation 2 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)		Injury at Work? 1 ∐ Yes 2 ∐ No		ow injury occurre		
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, offi	ice	28f. Location (S City or Tow	treet and Number n, State)	r or Rura	l Route Number,
	ne Hospit ne Funera ne Funera	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at th investigation, in r	ne time, date and pla my opinion, death oc	ce, and due to the c curred at the time,	cause(s) and man date and place, a	ner as st nd due to	ated. the cause(s)
	To the within the total conjugate to the tota	M	29b. Signature and title of certifier M. D.		ense number D39505	2	eptem	(Month, 1 ber	Day, Year) . 19, 260 7
	8		30. Name and address of person who completed cause of death (Item 23a) (Typ Yndhish Markon 305 Hospite	e, Print)	D39505 Glan Bu	mie, i	ND. 21	061	
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Physician Medical Examiner Physician Medical Examiner Physician Medic	\mathbf{B}_{a}	perm Depa Impo any I		21. Signature of Fahreral Service Licensee mol 35	I		•		MD 2	20910
De to (or as a consequence of): De to (or as a consequence of):	S. F. A.			Immediate Cause (Final disease or condition	e death. Do not er	nter the mode of dying, such	as cardiac or respiratory a	arrest,		Approximate Interval Between
Tank leading to immediate cause (injury fear of the cause				Due to (or as a co	,					
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Section Sect	/	cuted nd ransit	amin	cause. Enter Underlying Cause (Disease or injury that initiated events c.						
FFEMALE: FFEMALE:	90,	oe exe cian al ourial-1	EX	resulting in death) Last Due to (or as a co	onsequence of):					
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autopsy performed?	Box	the death certily the attending ached for use a	nysician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	Fetal death 3					
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25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manper of Death 1 Natural 2 Accident Silicide Check only one) 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28b. Describe how injury occurred 28b. Place of Death (Check only one) 27. Manper of Death 1 Natural 2 Accident 3 Double 4 Month, Day Year 28b. Describe how injury occurred 28b. Place of Injury 28b. Time of Injury 28b. Time of Injury 28b. Describe how injury occurred 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Describe how injury occurred at the time, date and place, and due to the cause(s) and manner as stated. 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Death (Check only one) 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Injury 28c. Disjury at Work? 1 Yes 2 No 28c. Place of Death (Check	900	g & S </td <td>plete</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>Were autop</td> <td>sy findings available</td>	plete						Were autop	sy findings available
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALLED BRIMER NO. 6121 MONTRESE ROAD RULLULLE, MARLAND 20852 State 31. Date filed (Month, Day, Year) 32#Registrar's Signature	on	nding th. :: After	tion	1 Natural 5 Pending (Month, Day Ye				now injury occu	reu	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALLED BRIMER NO. 6121 MONTRESE ROAD RULLULLE, MARLAND 20852 State 31. Date filed (Month, Day, Year) 32#Registrar's Signature	Divis	al or Atters after dear I Director	ertifica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury	- At home, farm, st Specify)	reet, factory, office	28f. Location (City or To	(Street and Num. own, State)	ber or Rural	Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALLED BRIMER NO. 6121 MONTRESE ROAD RULLULLE, MARLAND 20852 State 31. Date filed (Month, Day, Year) 32#Registrar's Signature		he Hospit in 24 hour he Funera pletely fille		(Check only 2 Medical Examiner: On the basis of ex	amination and/or in	th occurred at the time, date nvestigation, in my opinion, d	and place, and due to the death occurred at the time	cause(s) and m	anner as sta , and due to	ted. the cause(s)
P ALLED BRIMER, MD. 6121 MONTROSE ROAD RULLUILLE, MARYLAND 20852 State 31. Date filed (Month, Day, Year) 320 Registrar's Signature)	Se se se se se se se se se se se se se se	Σ	$\sim 1/11/1/10$						ay, Year)
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3	Physici /Medi		1. Decedent's Name (First, Middle, La	32)	e rlin Sr						oer 16, 2		3. Time of Death 1:15 PM
	Examir	er	4a. Facility Name (If not institution, giv Holy Cross Hosp:	ital	mber)			Spri			4c. County of Death Montgomery		
	Funeral Director		330-02-7039	ex □M 2∏XF	7. Age (In yrs. 61	last birthday) Yrs.	If Under 1 Ye Months Day		Min.	8. Date of Biri (Month, Da April 1	y, Year) 2, 1946	9. Birthi Coul Cal	place (State or Foreign ntry) ifornia
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland 10c. Street and Number 11207 Upton Driv 11. Marital Status 1 Never Married 3 Widowed 4 Divorced 15. Decedent's Ecspecify only highest graves Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last, Milton Merlin 19a. Informant's Name/Relationship (7E 12. Was Dec Armed Fc Armed Fc 1 □ Yes If Yes, Gi Year or D ducation College (**	edent Ever in U. prces? 2 X No ve ates:	16a. Deced (Give life. L Wri	Kensin 10f. Zip Code 208 Vas Decedent of Yes, specify C Yes 2 IN N ent's Usual Occ ind of work doi NOT use refu	B 395 If Hispanic Ouban, Mexica Io Specify Cupation Tred) 18. Moth	ost of work ner's Name arbar	ecify Yes or No Rican, etc.) ing e (First, Middle, a Smitt.	Specify 16b. Kind of Bu Screen Maiden Surnam	What Could Starter - Americals, White, Write, tes can Indian, etc. Thite dustry ting	
Baltimore, Ma	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic		Frederick T. Smy to 20a. Method of Disposition 1	Removal from	State Mor	11207 Place of Disposementery, crem ntgomen	Upton Sition (Name of latory or other p	Drive	, Ker Sept.	nsingtor 19,	n, Maryl 20c. Location - Bethes	and City or To	20895
08/00,	Physician // Medical Examiner bub/sician and step physician and step physician site paral-transit	edical Examiner	23a. Part1. En of the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Carc Due to b. Terr Due to c.	nach line. io Puln (or as a consequentinal Ox (or as a consequentinal ox) (or as a consequentinal ox)	nonary Jence of): Varian Janes of):	Arrest					1	Approximate Interval Between Onset and Death
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Records, P	requires that the een signed by the	ξ	Part II. Other significant conditions of	ontributing to de	eath but not resu	ulting in the un	derlying cause (given in Part	l. 	23e. Did to			ne cause of death?
vital Rec	an: The law ifficate has be or, page 2 sh	e Completed	25. Was case referred to medical					00 81	(D. 11	1□ Yes	rmed? d 21/2 No 1	prior to cou d <u>ea</u> th?	psy findings available mpletion of cause of 2 ☐ No
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ō	a Ph		27. Manner of Death	28a. Date	of Injury	28b. Time of	28c. In				ence 6 Othe		<u>y)</u>
UNISION	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	Certification:	1 XNatural 5 Pending investigation 3 Suicide 4 Homicide 5 Could not be determined	28e. Place	th, Day Year) of injury - At hong, etc. (Specify	Injury me, farm, stre	M 1	Yes 2]No		itreet and Numbe		I Route Number,
	he Hospita in 24 hours he Funeral pletely filled	Medical Ce	29a. Certifier 1 ⚠ Certifying Ph (Check only one) 2 ☐ Medical Exam	nner: On the ba	best of my know asis of examinat ner stated.	wledge, death ion and/or inv	occurred at the estigation, in m	time, date a y opinion, de	nd place, ath occurr	and due to the deed at the time, d	cause(s) and ma date and place, a	nner as st	tated. o the cause(s)
	To t To ti	Σ	29b. Signature and title of certifier				29c. Lice	nse number		2	29d. Date signed	(Month,	Day, Year)
)	10		30. Name and address of person who	completed caus	e of death (Item	23a) (Type, P		064100)		Septemb	er 16	5, 2007
	,		Smitha Bhikkaji, 31. Date filed (Month, Day, Year)	M.D. 1		est G1		l, Silv	ver S	pring,	Marylan	d 209	910
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 9 1 7 30365 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month September 14, 2007 **Physician** 12:15 AM Mary Louise Smith /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ft. Washington Hospital Prince George's Ft. Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | Oct. 12, 1938 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2ĀF Virginia 225-50-9571 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location ir than "naturel", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Prince George's Ft. Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20744 12021 Livingston Road e filed within 72 hours after death and Hygiene.
other than "naturel", or Items 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Secretary 12 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any liquy or other traumatic event SINB. 17. Father's Name (First, Middle, Last) Blanche Tines Thomas Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7672 Frogtown Rd., Marshall, VA 20115 Joan G. Collins (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 9/18/07 Hume, VA 5 Other (Specify) Mt. Morris Cemetery * 4 Donation Joynes Funeral Home, Inc. P.O. Box 3633, Warrenton, VA 20188 21. Signature of Funeral Service Utens e Ulmin 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lige. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pticemia. **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unious or mighty Due to (or as a consequence of): Examiner requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetel death 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Yes 2 □ No 9 Nunknown s been signed by should be detailed 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? certificate 1 Yes ₽ No Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Specify} \) 1 Yes 2 No Minpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A 2 Accident investigation the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 29a. Certifier 1 ី Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medica 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and 1112-91 142955 30. Name and address of person who completed sause of death (Item 23a) (Type, Print) Edgar V Potter, M.D. Asston Rd. Ff H washington. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene 30366 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 11:45 AM William Louis Seibert SEPTEMS OK 19 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOS P1792 SAM AKITAN BALTIMORG 6000 If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F Director 219-30-6662 74 April 22,1933 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore White Marsh 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "G" 3 Beeson Ct. Funeral 21162 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: δ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Police Officer Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Seibert Dorothy Remlein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) "G", White Marsh, Maryland 21162 Department of Health Important: If item 27 any injury or other to once. 3 Beeson Ct. Carmeen Seibert (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 09/20/2007 | Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service 9705 Belair Rd., Nottingham, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HUNGTING TON 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has I rector, page 2 s autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation ours after death.

neral Director; A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) MEDICAL ATTENDING 00062239 SOPTEMBER 19 2007 PHYSICI AN MAN NAME OG, MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMAR GOOD HOSPITAL BARTIMON-. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 1 2007

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene, 30367 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician September Day 16, KATIE PAULINE SCHOK 2⁷67 7 9:51 а м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Laurel Regional Hospital Laurel Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 24, **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min. $2\sqrt{X}$ 240-14-0972 North Carolina 86 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15814 Bradford Drive 20707 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 214 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes ŽŽNo Specify: à 3℃Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grade 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Wilson Lila Powell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kay Dwyer daughter 15814 Bradford Drive Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 □Cremation 3 □Removal from State Woodlawn Cemetery 09/20/2007 4 Donation 5 Dother (Specify) Baltimore, Maryland 21. Signature of Euneral Service Licensee Donaldson Fufferal Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the diseas shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death over 1 year **Physician** Arteriosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a eur sequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ♠ No 4□Pregnant at time of death Month Dav Year 5 Other (specify) the 9 Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Atrial Fibrilation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen cate has t page 2 s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2XXNo 24a. Was an autopsy certificate 1□ Yes 2CXNo 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2/ XNo 2 XXR/Outpatient 3 ☐ DOA ٩ 1 Inpatient funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1∰Natural 28b. Time of 28c. Injury at After Certification: 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No hours after death. uneral Director; / 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a **E-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 24721 September 17, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Syed Sadiq, M.D. 14333 Laurel Bowie Road, Suite 208 Laurel, Maryland 31. Date filed (Month, Day, Year) 32. Paistrar's Signature State Registrar SEP 2 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland Department of Health and Mental Hygiene Certificate of Death

Reg. No. Reg. No 2007 30368 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death September 11 **Physician** 8:21 PM Richard David Schultz 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Agnes Baltimore Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 92 yrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Mar. 7, 19 Birthplace (State or Foreign Country) **Funeral** Days Min. **№** M 2 🗆 F Hours Director 187-07-1376 1915 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 'natural', or items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes 2X No Director Baltimore Halethorpe 10g. Citizen of What Country?
United States 10e. Street and Number 10f. Zip Code 5817 Oakland Road 21227 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black. White, etc. My Yes 2 No 1942-If Yes, Give Year or Dates: 1943 1 Never Married Married 1 ☐ Yes 🌠 No Specify. Specify: White þ 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Eonce. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Oil Painter</u> Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Schultz Catherine Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5817 Oakland Road, Halethorpe, MD 21227 Edith Schultz - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State outon Park Cemetery 9-15-2007 4 Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Furieral A. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer Bladder **Physician** /Medical Due to (or as a consequence of): Heart Failure ongestive **Examiner** Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Records, P.O. Vital ō To the Hospital or Attending within 24 hours after death. Division

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) 2007

29b. Signature and title of certifier



DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year) September 11, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SEP MEMBERDAY 7, 2007 04:30A. *Emma P. Stilwell /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Center 4c. County of Death imore Examiner If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours Months Min. 1 □ M 2 1 → F 217-18-4093 Yrs. Director 85 Oct. 14, 1921 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits be notified at Director 1 ☐ Yes 🏖 ☐ No Maryland Baltimore Edgemere 10e, Street and Number 10f. Zip Code 10q. Citizen of What Country? ō or Items 23a 2825 Lodge Farm Roadmust Apt. 325 Funeral 21219 United States 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ₩idowed 4 Divorced "natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene, 12 years Sales <u>Liquor Store Owner</u> 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Parise ၉ <u>Mary Crivaro</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Connie Beam (Niece) 2809A Willow Avenue Edgemere, Maryland 21219 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ⊈Burial 2 Cremation 3 Removal from State Michaels Cemetery 9/19/2007 | St. 4 ☐Donation 5 Other (Specify) Frostburg, Maryland Funeral ervice Lice see 21. Signature 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CHRONIC OBSTRUCTIVE PULMONARY DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 I Inknown 9 Unknows been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð CONGESTIVE HEART FAILURE 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Iniury

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral within 24 hours a To the Funeral L

Medical 29b. Signature and title of certifie ABDALLAH J. 31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier (Check only one)

4 | Homicide

Helou, M.D

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance of the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

DØØ17695

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HELOU. M. D.

7601 OSLER DRIVE

TOWSON, MARYLAND 21204

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

		1 - State of N	•	artment of Heal	lth and Mental Hy ath	giene 007	30370
Physic	ian	1. Decedent's Name (First, Middle, Last)	<	Shaw	2. Date of Do Month	Day Year	3. Time of Death 12:31 A M
/Medi	cal.	MATEAILE TESS 4a. Facility Name (If not institution, give street and number	er)	4b. City, Town, or Loca	ation of Death	19 2007 4c. County of Death	
Exami	ner	1601 E. MADISON ST.	-	BALTIMO		BALTIMON	
Funeral Director		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday) Yrs.		Juder 24 Hrs. 8. Date of Bi Jurs Min. (Month, D	rth 9. Birth (Con)	nplace (State or Foreign
D D		Usual Residence of Decedent	10c. City, Town or Lo	ocation			10d. Inside City Limits
Maryla f shov	jo	10a. State 10b. County	BAltim				1 AYes 2 No
ith the or 28a	Directo	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	untry?
eath w	Funeral	1601 EAS + ///Adi	567 5T int Ever in U.S. 13.	Was Decedent of Hispan	nic Origin? (Specify Yes or N exican, Puerto Rican, etc.)	0- 14. Race - Ame	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itams 23s or 28s-1 show int. I'rs Medical Everth or mast be notified at		1 Never Married 2 Married 1 Yes 2	No l		exican, Puerto Rican, etc.) pecify:	Specify: D	A o L
15-003	ed by	3 Widowed 4 Divorced Year or Date	16a. Dece	edent's Usual Occupation		16b. Kind of Business/	ndustry
215 ithin 72 ien "ne	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40)	or 5+) life.	e kind of work done during DO NOT use retired)	g most of working	City H	SPITAL
d 212 filed withi Hygiene. other than		17. Father's Name (First, Middle, Last)	Nur		Mother's Name (First, Middle		OF HAL
arylan should be nd Mental markad o	To Be	48	E55	C	IArA Sn	nith	
INE, MARYIANG 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Itam 27 is marked other than "natural" or Itams 23s or 28s-f show other traumatic avant. Its Medical Examinatinast to incition at		19a. Informant's Name/Relationship (Type, Print) YUETT THREAT	19b. Maili		Number or Rural Route Numb A disen 5 +		
or Heal	13	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Sta	20b. Place of Dispo		Date	20c. Location - City or	Town, State
Pag Fent fent nrt: I		' 4 ☐ Donation 5 ☐ Other (Specify)	Mount	CARMEL		BAltimor	
Balti permit. Departm Importa any inju		21. Signature of Funeral Service Licensee Phillip A Weatherfor	2	1431 E. 011	Facility Ph. II : PA · ER ST BAIT	· more mi	12/2/3
		23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each immediate Cause (Final	n line.	5-1-4-21		arrest,	Approximate Interval Between Onset and Death
Physician /Medical	ı	resulting in death)	as a consequence of):	Dementi	a		years
Examiner	, in	Sequentially list conditions, b. Due to (or	as a consequence of):				
uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.					
18760, cate be executed physician and the burial-transit	ai Exa	resulting in death) Last Due to (or	as a consequence of):				
68760 ificate be e g physician as the buria	edicai	d					-102-
Box 68 leath certific attending p	Physician/Me		n 2 ☐ Fetal death 3[□Ectopic pregnancy		23d. Date of del Month	ivery Day Year
the de	hysic	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown		Other (specify)			
I Records, P.O. Box 6 The law requires that the death certific the has been signed by the attending F page 2 should be detached for use as	b	Part II. Other significant conditions contributing to deat	h but not resulting in the t	underlying cause given in		tobacco use contribute to Yes 2,⊠No 3 ☐ Pr	the cause of death?
Records, he law requires ti e has been signe age 2 should be c	Completed				24a. Wa	s an 24b. Were au	itopsy findings available
Rec The law ate has	omo					formed? death?	completion of cause of 2 No
f Vital Roysiclan: The Is certificate had director, page	Be	25. Was case referred to medical examiner?		Othor	Place of Death (Check only		
Division of Vital or Attanding Physician: T after death. Diractor: After this certificat din by the funeral director, ps	n: To	27. Manner of Death 28a. Date of		ant 3 DOA 4		sidence 6 Other (Special of the following of the followin	city)
Division of Attanding latter death. Diractor: After lin by the funer	Certification:	2 Accident investigation		M 1 ☐ Yes		(Street and Number or Ru	iral Route Number
Divi	ertifi	determined 200. Flace of	Injury · At home, farm, st , etc. (Specify)	treet, ractory, office		own, State)	na rioble rambor,
Division of Vita within 24 hours after death. To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical C	29a. Certifier Check only one) Check only one) Check only one) Certifying Physician: To the basis and manner.	is of examination and/or in	th occurred at the time, d nvestigation, in my opinio	late and place, and due to the in, death occurred at the time	e cause(s) and manner as , date and place, and due	stated. to the cause(s)
To the within To the comple	Me	29b. Signature and file of certifier		29c. License nui		29d. Date signed (Mont	
		M2, MD.		D 600	nore, MD	09/19/2	007
5		30. Name and address of person who completed cause (a. Hus Weiss 4940)	of death (Item 23a) (Type Ebtern A	ve. Balti	more, MD	212-24	
SI Regis	ate trar		gistrar's Signature				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** TOWNS 1:03 A M 2007 /Medical 4c. County of Death Facility Name (If not institution, give street and number) Examiner BALTIMORE Center VA MediCAL NIA BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 02 04 192 7. Age (In yrs. last birthday) **Funeral** 86 Months Days 1**X**M 2□ F 220. U. 41TT Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Yes 2 □ No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5305 Kenilworth 21212 WA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Employed Barber loth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Towns Thelma Mitchell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5305 Kenilworth Avenue Balto. MD 21212 Barbara J. Towns WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 □Removal from State Owings Mills, MD 09/25/07 Garnison Forest 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Vaugun C. Greene Funeral Sucs 21. Signature of Funeral Service Licensee 4905 York Rd. Baltimore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0315 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ NoNC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 10 Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA **Lirector**: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier Resident P21136 9-18-2007

State Registrar

3

DHMH 17 Rev 1/2001

10 North

GREENE STREET BALTIMORE MS 21201

Physician

distrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA

NORMAN BETENER

SEP 21

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland	Certificate of Death	Reg. No.	/
9,	Physici	an	1. Decedent's Name (First, Middle, Last)	2	. Date of Death Month Day	3. Time of Death
E	/Medic	al	Charles R. lurner	the Other Travers are location of Docth	09 17	Zoc7 8 2 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) Onivers. To Special Hospit	4b. City, Town, or Location of Death		altinone City
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. le	Months Dave Hours Min	Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
Ġ.	Director		219-16-3832 1921 M 2 L F 82	Yrs. World Do	ec.19,1924	Maryland
	yland now at			, Town or Location		10d. Inside City Limits
	e Mar 3a-f sh tiffied	Director	Maryland Harford	Abingdon		1 ☐Yes 2 M No
	with th	Dire	10e. Street and Number	10f. Zip Code 21009		ten of What Country?
	ms 23	Funeral	3135 Birch Brook Lane 11. Marital Status 12. Was Decedent Ever in U.S.			4. Race - American Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	Armed Forces? 1 □ Never Married 2 □ Married 1 ■ Yes 2 □ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2 M No Specify:		Black, White, etc. Specify: White
15-0	"natu	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kin	nd of Business/Industry
121	within lene. than the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Painter	Pa	inting
	al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)		First, Middle, Maiden S	Surname)
ylar	2 should be filed w n and Mental Hygie 'Is marked other ti raumatic event, th	70	Raymond Turner		McKenny	
Maryland	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Type. Print) Carol Ann Barwick (Cousin)	19b. Mailing Address (Street and Number or Rural H 3135 Birch Brook Lane,		
	s 1 and 2 if Health item 27 l		20a. Method of Disposition 20b. Pl	ace of Disposition (Name of emetery, crematory or other place)		cation - City or Town, State
Baltimore,	a = = >		1 I I I I I I I I I I I I I I I I I I I	view Crematory 09-19-	07 Balt	imore, Maryland
Balt	permit. Pages 1 a Department of Hee Important: If item any Injury or othe		21. Signature of Funeral Service Licensee	McCully-Polyniak Fun	Baltimore.	P.A. Marvland 21230
			23a art1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not enter the mode of dying, such as cardiac or i	respiratory arrest,	Approximate Interval Between Onset and Death
à.	Physician /Medical	6	Infimediate Cause (Final disease or condition resulting in death)			1 day
	Examiner		Due to (or as a consequ	Ventilation		3 months
	n #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):		3 months
Y	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequ	structive Pulmanany	Dixerse	· loyears
68760,	e be ex	Za E		,		
		Medical				
Box	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal	death 3 ☐ Ectopic pregnancy	2	3d. Date of delivery Month Day Year
P.O. F	the dea	ysic	1 ☐ Yes 2 No 4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5 Other (specify)		
	w requires that the d been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resu	Iting in the underlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?
ords	equire en sig ould b	ted t	Pulmonary hypertension	\	1)Z Yes 2	No 3 Probably 4 Unknown
Seco	e law r has be je 2 sh	Completed	Atrial Fibrillation		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
alF	iclan: The certificate ector, pag		Dispetes mellitus 25. Was case referred to medical	Of Plans of Darkh (performed? 1□ Yes 2M No	death? 1 ☐ Yes 2 No
or Vital Records,	Physiclan: this certific	To Be	examiner?	26. Place of Death (ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 Residence 6	G □Other (Specify)
n 0	ding Physician: The lar n. After this certificate has funeral director, page 2		27. Manner of Death 1. Natural 5 Pending 28a. Date of Injury (Month, Day Year)	Injury Work?	d. Describe how injury	/ occurred
Division	ttendi death. stor: A r the fu	icati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury. At hou	M 1 ☐ Yes 2 ☐ No me, farm, street, factory, office 28	f Location (Street and	d Number or Rural Route Number,
Div	alor A after Direct d in by	Certification:	4 Homicide determined building, etc. (Specify		City or Town, State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical (wledge, death occurred at the time, date and place, ar tion and/or investigation, in my opinion, death occurred		
	To th To th comp	Me	29b. Signature and title of certifier	29c. License number		e signed (Month, Day, Year)
	~		com 14	D0061882		-17-2007
	3		30. Name and address of person who completed cause of death (Item	23a) (Type, Print) O(S. Charles Stree	+ Balt	more MD 71230
	Sta Registi		31. Date filed (Month; Dal); Yell / 32. Thatrar's Signat	de Apartie		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 **Physician** Bernadine Peterson Terrance 09 18 12:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5217 Tilden Rd. Bladensburg Prince George's 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 6 Sex Days 438-28-8991 1 □ M 99 Director 11-18-1908 Louisiana Usual Residence of Decedent filed within 72 hours after death with the Maryland a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Prince George's **Bladensburg** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5217 Tilden Rd. items 23a c iner must be 20710 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or items edical Examiner m Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental John Peterson ဂ္ Marietta Jane Antoine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is Betty Wilkinson/daughter 5217 Tilden Rd. Bladensburg, MD20710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of 9-28-2007 New Orleans, LA Mt. Olivet Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MD 20910 Rapp Funeral & Crem.Sv.933 Gist Av.Silver Spring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Failure to Thrive /Medical Due to (or as a consequence of): Examiner Alzheimer's Dementia Sequentially list conditions, it is a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to jor as a consequence of Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical the attending properties as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Peripheral Vascular Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an <u>Hypertension</u> autopsy page performed? Yes 2 No certificate Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Inpatient this. 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the 1 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) filled in by 4 Homicide 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

Division or Vital Records, P.O. Box 68760 within 24 hours after death To the Funeral Director: Hospital completely

> State Registrar

29b. Signature and title of

30. Name and address of

Dr. Kathy Brenneman 1160 Varnum St. NE #021 Washington, DC 20017 31. Date filed (Month, Day, Year) 2007

32 Registrar's Signature

erson who completed cause of death (Item 23a) (1)po, Print)

29c. License number

D0051473

29d. Date signed (Month, Day, Year)

9-19-2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 550 **Physician** homas 07 /Medical 4a. Facility Name (If not institution, give street and nur 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS Medical entar Balt more If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1□ M 2 💢 E 218.88.2290 Yrs. Director unk Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director Yes 2 □ No MD Battimore 10e. Street and Number 10g. Citizen of What Country? OK U.S.A Items 23a 7760 21204 Be Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iter any Injury or other traumatic event, the Medical Examiner Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk. unk. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk မ unK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. Russ (Funeral Director) W Dette. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 R 3 ☐Removal from State Dundalk MD unlined! of Funeral Service Licen 21. Signa 2222 W. North AVENIE Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) tegoned /Medical Due to r as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the attending physician and ched for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 No Nown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director. A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Glen Purnie 2842 luneses 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

SEP

2007

			1 - For State Registrar	S	State of N	Marylan		artmen <i>rtificati</i>				ental Hy	gien Reg. No		I	30313
			1. Decedent's Name (First, Midd	lle, Last)	-			_				2. Date of De		,	Year	3. Time of Death
	Physici		Wosley	17	7		7	home	30 N	Ji	-,	Scoten2	Day X. 2		007	1415 PM
	/Medio Examir		4a. Facility Name (If not institution	n, give stre	et and numbe	r)				Location	of Death			County	of Death	
1	LXaiiiii	. ICI	The Johns H	POPKI	ns Hz	spita	a /	Bak	time	ore	Ci	ty				
	Funeral		5. Social Security Number	6. Sex	- 11		last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir (Month, Da	th Your		9. Birthpl	ace (State or Foreign
	Director		230-68-1794	1 🔀 M	1 2□F	57	Yrs.	Months	Days	Hours	Min.	Mar. 6	, 19	50	Vire	inia
-			Usual Residence of Decedent													
	72 hours after death with the Maryland naturel, or Items 23a or 28a-f show dical Exercit per rest be ricettled at		10a. State 10b. Count	4		10c. City	y, Town or Lo	ocation							11	0d. Inside City Limits
	Mar.	to	VA Fred	erick		Ste	phens	City								1 ☑ Yes 2 ☐ No
	1 the	Director	10e. Street and Number					10f. Zip	Code				10g. Cit	izen of W	hat Coun	try?
	With With	0	204 Fairfax Dr	ivo				2	2655				US	Δ.		
	ours after death with the Marylan rel', or Items 23a or 28a-1 show Eserott et rest be notified at	Funeral	11. Marital Status		Was Deceder	nt Ever in U.	S. 13.			spanic Or	igin? (Spe	cify Yes or No Rican, etc.)		14. Race		an Indian,
40	ter o	5	1 ☐ Never Married 2 ☐ Ma	rried	Armed Force:	7 No						tican, etc.)			, White, o	
336	urs al	b	3 ☐ Widowed 4 ☑ Divorce		If Yes, Give Year or Dates	1977		1 ☐ Yes	2⊠ No	Specify:				Specify:	Bla	ick
ŏ	72 hours after dea "naturel", or Items	pa	15. Decede			1990	16a Dece	dent's Usua	al Occupa	ition			16b. K	ind of Bus	siness/Inc	lustry
15	in 7	Completed	(Specify only high	est grade o	College (1-40	· F.\	(Give	kind of wo	rk done d se retired	luring mos)	it of workin	g				
12	filed within Hygiene. Her than "	Шо	Elementary/Secondary (0-12)		2	1 3+)	Dete	ntion	Off:	icer			Det	tenti	on C	enter
0	filed Hyg other	e C	17. Father's Name (First, Middle	, Last)						18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)	
Maryland 21215-0036	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Max	To B	Wesley M. Tho	mneon	Sr					Dor	is Ca	atlett				
<u>-</u>	houl id Ma marf mati	F	19a. Informant's Name/Relation				19b. Maili	ng Address	(Street a			Route Numb	er, City	r Town, S	State, Zip	Code)
Za	d 2 s th ar tris trau		Wacovia Thomps			ohter	204	Fair	fax 1	Drive	. Ste	ephens	Cit	v. VA	22	.655
	as 1 and 2 of Health a item 27 is		20a. Method of Disposition	011 110	illa, Daa	20b. P	lace of Dispo	sition (Nar	ne of	1		ate		ocation - (wn, State
ō	Pages nent of H ant: If ite ury or of		1 ⊠Burial 2 □ Cremation		noval from Star	e Sh	emetery, cre enando	ah Me	ther place MOTI	a1	9-22	-07	T T -	.1		77A
ij	Pa tmer tent jury		`4 □Donation 5 □ Other (metery							ches		
Baltimore,	permit. Pages 1 and 2 should be fited within 72 ho Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturany injury or other traumatic event, Ira Mudica. Once.		21. Signature of Funeral Service	Licensee	-10	^	2	2. Name an	a Addres	s of Facili		rtwrig				
_	<u></u>		prend	Ju 1	Jaki	٧						nchest		VA	2260	
		1	23a. Part 1 Enter the disease, of shock or heart failure. Lis	r complica t only one	tions that caus cause on each	ed the deat line.	h. Do not en	ter the mod	e of dying	g, such as	cardiac or	respiratory a	ırrest,			Approximate Interval Between Onset and Death
100	Physician		Immediate Cause (Final disease or condition		· H	MODX	ric 1	BRAIL	7 I	つびひ	24					5days
4	/Medical		resulting in death)	(a.	Due to (or	as a conseq	uence of):									
н	Examiner		a control for the second	ь	C	ording	uence of):	1014	Arro	5}						Doays
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	J "-	Due to (or a	as a consec	uence of):									
4	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events	1												
,	exec in an	Exa	resulting in death) Last	0.5	Due to (or a	as a conseq	uence of):									
8760,	cate be executed physician and the burial-transif	dical		d												
.89	ficat g phy is the	edic														
Вох	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c	. If yes, outcon			7-						23d. Date	of delive	ry
ă	atter for	ciai	in the past 12 months?		1☐Live birth 4☐Pregnant			⊒Ectopic pr ∃ Other <i>(sp</i>						Mon	th	Day Year
O.	the d	ysi	1 Yes 2 No 9 Unknown		9□Unknown											
Δ.	that the de ned by the a detached f		Part II. Other significant condit	ions contri	buting to death	but not res	ulting in the u	inderlying c	ause give	n in Part I	ı.	23e. Did	tobacco	use contri	bute to th	e cause of death?
Vital Records,	sign d be	d by										1 🗆	Yes 2	No	3 ☐ Prob	ably 4 □Unknowr
Ö	w requir been si should	Completed										24a. Was		24h M	lore auto	psy findings available
ec	e law has b	du										auto		P	rior to cor	npletion of cause of
<u>=</u>		Co										1 ☐ Yes	2 X No		Yes	2□ No
/ita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medic examiner?								e of Death	(Check only	one)			
of \	8 × =	2	1 ☐ Yes 2 No		ipital: 1 XInpa		ER/Outpatie			4 🗆 N		ne 5⊟Res				/)
0	ding Phy h. After thi funeral o		27. Manner of Death 1 Natural 5 □ Pend	ing	28a. Date of It (Month, I	njury Day Year)	28b. Time of Injury	of 2	8c. Injury Work			8d. Describe	how inju	ry occurre	ed	
Division	ath. or: Ar	atic	2 Accident inves	tigation				М	1 🗆 '	Yes 2□						
Vis	er de recto by ti	tifle	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined		Injury - At he etc. (Specif	ome, farm, st	reet, factory	, office		2	8f. Location (City or To			r or Rura	l Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification;														
	ospi hour uner y fille		29a. Certifier 1 Certify (Check only 2 Medica	ing Physic	ian: To the be	st of my kno	wiedge, deal	h occurred	at the tim	ne, date a	nd place, a	nd due to the	cause(s	and mar	nner as st	ated. the cause(s)
	n 24	Medical	one)		and manner	stated.										
	To the Vithin To the To the Somp	ž	29b. Signature and title of certif	er				290	. License	number			29d. Da	te signed	(Month,	Day, Year)
			B. SHOM Hom	TAX .	Madial	Doct	00		R	65-	000		Scat	cmben	17	2007
			30. Name and address of person	n who com	pleted cause of	f death (Iten	n 23a) (Type	Print)	4 ,		-					
	10		29b. Signature and title of certification. 30. Name and address of person. 31. Date filed (Month, Day, Year SEP 2.1	J-1-	Hartine	Hasai	tal AM	North	Wol	fc Str	cet 1	Bultimon	c Ma	rylon	1 2	1287
	Sta	ato	31. Date filed (Month, Day, Yea	r)	32. Regi	strar's Signa	iture 8	M 0					2 10	1		
	Regist		CED 9 1	2007	Don't	a Life	11270	San San San San San San San San San San								

1 - State Certificate of Death	n Reg. No. 2007 3037
1. Decedent's Name (First, Middle, Last)	Date of Death Month Day Year 3. Time of Death Year
/Medical MARGARET ALEXANDRA TERL	SEPTEMBER 18 2007 6:48 A
Examiller	WSON BALTIMORE
	er 24 Hrs. 8. Date of Birth Min. 11/01/1957 9. Birthplace (State or Fore
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Lim
ARROLL HAMPSTEAD	1 □Yes 2√
106. Street and Number 10f. Zip Code 21074	10g. Citizen of What Country? U.S.A.
TEDIO OF THE PROPERTY OF THE P	I WHITE
15. Decedent's Education (Give kind of work done during me life. Do NOT use retired)	16b. Kind of Business/Industry
The state of the s	MARKETING
Note that the plant of the first ther's Name (First, Middle, Maiden Surname) EATRICE GOLD	
불문토 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Num	nber or Rural Route Number, City or Town, State, Zip Code)
20h Place of Disposition (Name of	ROAD - HAMPSTEAD, MD 21074 Date 20c. Location - City or Town, State
20a. Method of Disposition 1 Burial 2 Termation 3 Removal from State 4 Donation 5 Other (Specify)	
22. Name and Address of Face	SOL LEVINSON & BROS., INC. TOWN ROAD - PIKESVILLE, MD 21208
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line. Immediate Cause (Final	as cardiac or respiratory arrest, Approximate Interval Between Onset and Death
/Medical disease or condition resulting in death) a. Due to (or as a conse u nce of):	years
Examiner Sequentially list conditions, if any, leading to immediate b	
Per per per per per per per per per per p	
rifficate be as the burner of a street of	1.
Cause: Personal State of the page of the p	23d. Date of delivery Month Day Year
O o the tension of the condition of the	rt I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
	24a. Was an autopsy findings availa prior to completion of cause death? 1
25. Was case referred to medical examiner? 1	ace of Death (Check only one)
The state of the s	Nursing Home 5 ☐ Residence 6 ☑Other (Specify) VC3 [30] 28d. Describe how injury occurred
M 1 Vos 2	□No 28f. Location (Street and Number or Rural Route Number,
27. Manner of Death 1	City or Town, State)
29a. Certifier (Check only only only only only only only only	death occurred at the time, date and place, and due to the cause(s)
### 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
) S	0303 September 18 200
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMON J. CHANNES M. 6701 N-(Montles ST	29d. Date signed (Month, Day, Year) September 12 200 - Powson MD 4204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30377 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sept. 73 2007 Cornelius Van Dyke 5:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3414 Sollers Point Road Baltimore Dundalk 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year)

December 24,1922 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F 84 Yrs. Director 215-18-6598 New Jersey Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be anone. 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits Dundalk 1 ☐ Yes 2 No Maryland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 3414 Sollers Point Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ¶Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Western Electric Security Guard 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Delmar Thorton Cornelius Van Dyke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3414 Sollers Point Road, Dundalk, MD. 21222 19a. Informant's Name/Relationship (Type. Print) wife Mary A. Van Dyke 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 21, Baltimore City, MD. 4 □ Donation 5 □ Other (Specify) 2007 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a, Fart1. Enter the diseas Fart1. Enter the diseas, or complications that caused the dealn. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** arter Conary /Medical Due to (or as a con equence of): **Examiner** Sequentially list conditions, Due to for as a ponsequence of: Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Physician/Medical attending philor use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2⊒No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ို 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1. Natural 1 ☐ Yes 2 ☐ No ours after death.

neral Director: /
filled in by the fi 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760 within 24 hours a

To the Funeral C

completely filled

> State Registrar

0

1005

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

091

2007

Say

31. Date filed (Month, Day, Year)

Reza

0018951

Point Blud Swite 706 Balto, Molaray

			1- State of Marylan Registrar		artment of H rtificate of L			iene eg. No. 2 N (17 30378
	Physici /Medic		Decedent's Name (First, Middle, Last) EDITH ELIZABETH VEITH				2. Date of Deat Month Septembe	er 15, 2	3. Time of Death 007 7:04 P. M
S Jacob	Examir		4a. Facility Name (If not institution, give street and number) Gilchrist		4b. City, Town, or Tows	son		4c. County of Balti	
ĺ	Funeral Director		5. Social Security Number 216-12-6953 Usual Residence of Decedent 6. Sex 1 M 2X F 7. Age (In yrs. 83)	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 2.	3, 1923). Birthplace (State or Foreign Country) Maryland
	he Maryland 8a-f show otified at	Director	10a. State 10b. County 10c. City Maryland Baltimore	, Town or Lo Baltir	more				10d. Inside City Limits 1 ∐Yes 2MNo
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Dire	10e. Street and Number 7826 Hillsway Avenue 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		10f. Zip Code 2 Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2 No	21234 spanic Origin? (S n, Mexican, Puert Specify:			
3 21215-0(filed within 72 hou Hygiene. other than "natura ent, the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 years 17. Father's Name (First, Middle, Last)	(Give life. I	dent's Usual Occupa kind of work done of DO NOT use retired anager	luring most of wor	king	16b. Kind of Busin	ness/Industry
aryland	2 should be f and Mental h is marked of aumatic ever	To Be	Samuel Oliver Bowen 19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a	Gertru	ide May	Kane	ate, Zip Code)
Baltimore, Maryland 21215-0036	Pa Pa		4 □ Donation 5 □ Other (Specify)	lace of Dispo emetery, crer	Hillsway sition (Name of natory or other place rest Vetera	e)	Date :	20c. Location - Cit	: ::11 - Massall - : :1
■ Bal	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee	M 6	Name and Address itchell-W 500 York er the mode of dying	s of Facility iedefeld Road Ba	l Funeral ltimore,	Home, I Marylan	nc. d_21212 Approximate
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (final disease or condition resulting in death) Sequentially list conditions, b.	ence of):		9, 000, 000	or respiratory and		Interval Between Onset and Death
8760,79	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that intitated events resulting in death) Last Due to (or as a consequence of the consequence o				_		
P.O. Box 6	eath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
Records, F	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resu	Iting in the ur	nderlying cause give	n in Part I.	23e. Did tob		ute to the cause of death?
		Completed		-			24a. Was ar autops perforn 1∐ Yes 2	y prio ned? dea	re autopsy findings available or to completion of cause of ath? JYes 2 □ No
r Vital	Physician: The this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Othe		th <i>(Check only one</i> ome 5 ☐ Reside		(Specify) HDSPICE
Division or	Attending I death. ctor: After y the funer	Certification:	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 4 determined 28a. Date of Injury (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Place of injury - At hobiliding, etc. (Specify	28b. Time of Injury me, farm, stre	Work M 1□1	at ? ∕es 2 □ No	28d. Describe ho 28f. Location (Str City or Town	reet and Number	or Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinat and manner stated.	vledge, death ion and/or inv	occurred at the time estigation, in my op	ne, date and place pinion, death occu	, and due to the ca	ause(s) and mannate and place, and	er as stated. d due to the cause(s)
)	To the within 2 To the Comple	Me	29b. Signature and title of certifier		29c. License	number 4395	29	9d. Date signed (A	Month, Day, Year) SER 19, 2007 -, MLD 21224
	5		30. Name and address of person who completed cause of death (Item DAN/EWE DOBERMAN) MO 656	23a) (Type, I	Print) HARLES S.	8UITE	216 87	TIMERE	, MD 21204
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 1 2007	ure	ji d				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 30379 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Year September 17, 2007 1725 hrs Medical Examiner 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Good Samaritan Hospital 9. Birthplace (State or Foreign 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Country) Months Davs Hours Director M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 No or items 23a or 28a-f show must be notified at once, the Maryland Director 10g. Litizen of What Country 10e. Street and Number A 14. Race - American Indian, Black, Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? 2 Married Never Married Yes Give Year 2 X No specify: Yes of Health and Mental Hygiene.
If item 27 is marked other than "battiral", ther traumatic event, the Medical Examiner. Widowed Divorced 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr 15: Decedent's Education (Specify only highest grade completed) Completed. during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) filed within 72 21215-0036 (UNKNOWN) 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print S S timore, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Location - City or Town Randallstown. crematory or other place) Burial or other 2 Cremation Removal from State permit Pages Department of Important: ponation 5 Other Specify. 22. Name and Address of is ature of Funeral Service License ROW Part I. z ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are st, shock, or hear Approximate Interval Between Onset and Physician failure list only one cause on each line /Medical a Hypertensive atherosclerotic cardiovascular disease immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical AMENDED #23a,PII,27,p TIFM#20c,perFH X UNPENDED ned by the attending physician detached for use as the burial me G880 /20/08 TT To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Live birth 3 Ectopic pregnancy Month Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 V No 9 Unknown g Unknown contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions Records, P.O. δ Yes 2 No 3 Probably 4 ✔ Unknown Diabetes mellitus. end stage renal Completed 24b. Were autopsy findings available peen 24a, Was an prior to completion of cause of autopsy has b performed? death? ✓ Yes 2 1 🗸 certificate 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be examiner? Other₄ Hospital: DOA Other 2 **V** ER/Outpatient Nursing Home 5 Residence 6 Inpatient After this ို 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fun 1 X Natural Yes 2 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 18, 2007 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a)

Registra

DHMH 17 Rev 1/2001

OCMF 2006

State

Jack Titus MD.

Deputy Chief Medical Examiner

2007

32 Registrar's Signature

BURN

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 30380 1. Decedent's Name (Fjrst, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Wyche Juendolyn 1:54 PM 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harbor Hospital Center 3001 S. Hanover NIA Baltimore, MI If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F Months Hours 216-42-0417 62 Director FEBRUARY 18,1945 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show BALTIMORE **Funeral Director** MARYLAND 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? ns 23a or 7 SETHLOW ROAD Department of Health and Mental Hygiene. Invois and loss Important: If Item 27 is marked other than "natural", or Items, any Injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Pages 1 and 2 should be filed within 72 hours afternent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BALTIMORE CITY SCHOOL 4 YEARS EACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MADDIE ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WYCHE (HUSBAND) IGOS N. HILTON ST., APT. BI, BALTO, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State KING MEMORIAL PARK 109-22-2001 BALTIMORE, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
505EAH H. BROWN JR. FUNERAL HOME
840 N. FULTON AVE, BALTIMORE, MTD 21817 21. Signature of Funeral Service Licensee h N. Williams 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** sepsis due to mesenteric ischemia 4 days /Medical Due to (or as a consequence of): Acute renal failure Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed failure live Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Respiratory Physician/Medical the nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an has 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number

State Registrar

3001 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hartorphospital

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chanoverst.

29d. Date signed (Month, Day, Year)

Baltimore, MD, 21225

18

2007

		1	For State	State of Maryland	Department of Health and N Certificate of Death		2001	30381
Dh			1. Decedent's Name (First, Middle, Last	14/51	Certificate of Beatif	Reg. N 2. Date of Death Month D	ay Year	3. Time of Death
/M	/sicia ledica	il -	As. Facility Name (If not institution, give	WILSON	4b. City, Town, or Location of Death	Sept 8	2007 c. County of Death	4:10A M
EX	amine		Blue Poin	+ NSq. Hon	ne Baltimore	P. Date of Birth	NA	lace (State or Foreign
Fune Direc		5	217-10-2700	x 7. Age (In yrs. last	Yrs. Months Days Hours Min.	8. Date of Birth Historich, Day, Yang Feb. 1, 19	14 1910	cryland
rylend	a		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location	•	1	0d. Inside City Limits
the Ma	rotifie	Director	Md. 10e. Street and Number	4 B	altimore 10f. Zip Code	10g. C	itizen of What Coun	1 Ser 2 No htry?
death with the Marylend me 23a or 28a-f ehow	nust be	erai Di	1110 Stoda	ara Ct. 12. Was Decedent Ever in U.S.	2/201	ecify Yes or No.	USA 14. Race - Americ	an Indian
36 after de or item	miner	y Fun	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give	 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify: 	Rican, etc.)	Black, White,	
5-0036 72 hours after	lical Ex	Completed by Funeral	3 Widowed 4 □ Divorced 15. Decedent's Edi (Specify only highest grad		6a. Decedent's Usual Occupation (Give kind of work done during most of work		Kind of Business/Inc	dustry
Maryland 21215-0036 d 2 should be filed within 72 hours aff th and Mental Hygiene. T is marked other then "natural", or	IT WE	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	Surgical Tech.		HOSP	ital
land 2 Id be filed ental Hygi ked other	c event,	Be	17. Father's Name (First, Middle, Last)	en Hill	18. Mother's Name	e (First, Middle, Maide	n Sumame)	0.00
IOTE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Marylen to Heelth and Mental Hygiene. If tem 27 is marked other then "natural", or iteme 23a or 28a-1 show	raumati	2	19a. Informant's Name/Relationship (T	(Son)	19b. Mailing Address (Street and Number or Run	Route Number, City	or Town, State, Zip	Code)
Ore, Not the stand of Heelth	r other t	-	20a. Method of Disposition	cemi	e of Disposition (Name of etery, crematory or ether place)	Date 20c.	Location - City or To	own, State
Pa Pa	injury o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Funeral Service)Licens	Ivar	yland National 7/24	12007 Le	urel,	Md.
Balti permit. Depertri	any ir		Vase ph	L'KUSA	Josephy Russ t	Averal	tome p	4-1216 Approximate
Physic	ian		23a. Part 1. Enter the disease, or comp speck, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	endie	Interval Between Onset and Death
/Medi Exami	ical		resulting in death)	Due to (or as a consequen	ice of):			
200	Sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequen	ce uf).			
58760, <	rial-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequent	ice of):			
68760, ificate be ex g physicien	as the bu	edicai		d				
.O. Box 687 the death certificate y the ettending phys	for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deatl	ath 3 Ectopic pregnancy		23d. Date of delive Month	ery Day Year
T ta b	detached		9 🗆 Unknown	9□ Unknown ptributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the	ne cause of death?
Division of Vital Records, P for Attending Physicien: The law requires tha effer death. Director: After this certificate has been signed 1	eq pinor	ted by	Parler	B 2 (noe	isease	1 ☐ Yes		
Records, P. The law requires that	page 2 st	Completed	Maren Os	roug and	en Disease	24a. Was an autopsy parformed?	prior to con death?	psy findings available impletion of cause of
of Vital Physician: T	ctor	Be	25. Was case re to medical examiner?	Hospital:		h (Check only one)		(
On of ding Phys h. After this	nera	on: To	27. Manner of D→ th 1 🗗 Natural 5 🗆 Pending		3b. Time of 28c. Injury at Work?	28d. Describe how in		y)
Division of or Attending offer death.	by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No e, farm, street, factory, office	28f. Location (Street a		al Route Number,
DIVISIO To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A	ly filled i				dge death consumed at the time date and place, and/or investigation, in my opinion, death occur			
Fo the H within 24 Fo the F	complete	Medicai	29b. Signature and title of certifier	and manner stated.	22c.*License number		ate signed (Month,	1
)	1) (fora	13.6	20/Time But)	20	1117	101
	\		30. Name an address of person who	ARK H	EROHIZ KAN	E. 38	uto,	or D. 2121
Re	Sta gistra		31. Date filed (Month, Day, Year) SEP 2 1 20	32 Registrar's Signation	Locales			

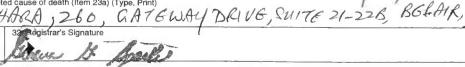
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30382 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Kenneth Elwyn Wessel 11:20 A^M /Medical September 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign
Country) **Funeral** 11X7M 2□ F 375-24-1349 Director 78 April 9, 1929 Michigan Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 28a-f show be notified 1 ☐ Yes 2 No Director Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or "natural", or items 23a 2100 Bayberry Road 21040 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. δ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Soldier U.S. Government Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental Joseph Valentine Wessel Mary Elizabeth Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2:
Department of Health as Important: If item 27 is any injury or other trauonce. 2100 Bayberry Road, Edgewood, MD 21040 Margarete P. Wessel / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hilltop Service Corp. 9-18-07 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. a am 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MECHANICAL DISSOCIATION Physician /Medical Due to (or as a consequence of): Examiner IDIO PATHIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed RESPIRATO CUTE sician and bunial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 s has 1□ Yes 2 Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To Ö thiis filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) SEP 2



1260

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For Amend Item 1 - Registrar	2 State of Mi	ryland	71 Dep Ce	9721) rtificate	7ah e of L	ealth a Death	and Me	ental Hyg	iene _{eg. N} 2 (07	30383
	Physic		1. Decedent's Name (First, Middle, Li	· · · · ·	10						2. Date of Dea Month August	Day	2007	3. Time of Death 2/30 P M
	/Medi Examii		4a. Facility Name (If not institution, gi	ve street and number)		/			Location o	of Death	707020		nty of Death	
	Funeral Director			Sex 1 2 M 2 □ F	e (In yrs. Ia:	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Aug. 10,	Year)	9. Birthp Coul	olace (State or Foreign ntry) NC
	e Maryland ta-f show tified at	ctor	10a. State 10b. County MD		10c. City,	Town or Lo		Baltin	pre					10d. Inside City Limits XX Yes 2 □ No
	with the	I Dire	10e. Street and Number 833 West Pratt Street		-		10f. Zip	Code	2120	1 1	1	0g. Citizen o	of What Cou	ntry?
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Maryland 21215-0036	within 72 ho ene. than "natui he Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	+)	(Give	dent's Usua kind of wor DO NOT us	k done di e retired)	uring most				Business n	dustry
nd 2	al Hygid I other	Be Co	17. Father's Name (First, Middle, Las	•			correc				First, Middle, I		Maryla ame)	and
ryla	should k nd Ment marked matic e	2	Turner W	illiams, Sr.	T	19h Mailir	on Address	(Street a	nd Numbe		Mable L.			Codel
	ゆきとき		Regina Sykes / Niece	Typo. 7 Tilly		1321 F	lerkime	r Str	eet; E	Baltimo	ore, Mary	land 2	n, State, 215 21223	(Coae)
nore	ages 1 ent of He t: If Iter y or oth		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □		cer	netery, crei	sition (Nam matory or ot	her place	i	Da			n - City or To	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		Garri	son Fo					007 (71ie Fune Baltimo			Maryland 21217
8/60,	Physician /Medical Examiner bulking the prival-transit	dical Examiner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, france, leading to manufacture cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that caused one cause on each lin a. Due to (or as a Multip Due to (or as a Out to (or a) Out to (or a)	a conseque le My	Rence of): elona nes of):	J F.	gilo	re	cardiac or	respiratory arro	est,		Approximate Interval Between Onset and Death
O. Box 6	eath certi attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal d	eath 3□]Ectopic pre] Other <i>(sp</i> e						Date of delive	ery Day Year
S, T	w requires that the d been signed by the should be detached		Part II. Other significant conditions of Metastatic Aden											ne cause of death?
Hecords,	The lar ate has page 2	Completed by	Failure, Malnut			IVCI	кевр.	пац	<u>JL</u> y	_	24a. Was autops	v	D. Were auto prior to col death?	psy findings available npletion of cause of
VITA	Physician; this certific al director,	o Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	- 0000	2/0		0.4			Check only on	9)		
ion or	this d	F 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Z Inpatier 28a. Date of Injur (Month, Day	y 2	8/Outpatien 8b. Time of Injury	t 3 □ DOA 28	c. Injury : Work?	4 LI Nun	28	e 5 Reside d. Describe ho			y)
DIVISION	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After tompletely filled in by the funeral process.	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of inju- building, etc	ry - At home . <i>(Specify)</i>	e, farm, stre	et, factory,	office		28	f. Location (St. City or Town		mber or Rura	l Route Number,
	ne Hosp 24 hou ne Funer letely fill	edical	29a. Certifier (Check only one)	ysician: To the best o niner: On the basis of and manner stat	examination	edge, death n and/or inv	occurred a restigation,	t the time in my opi	e, date and nion, deat	d place, an th occurred	d due to the ca	use(s) and ate and plac	manner as s e, and due to	ated. the cause(s)
) •	To th withir To th comp		29b. Signature and title of certifier	A	1.		29c.	License i	1 2 9.	50	29	od. Date sign	ned (Month,	Day, Year)
	الل		30. Name and address of person who	completed cause of de	ath (Item 20	3a) (Type, I	Print) Ba	141.	4010	-, /	40 0	2/2:	23	1
	Sta Registr	_	31. Date filed (Month, Day, Year) SEP 2 1 2007	32. Registra	r's Signatur	best	9		-			,		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1-Arternd #26 Per PHY g871 9/21/07 JH Certificate of Death Reg. NO. 30384 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** September 13, 2007 Tyrone Μ. Williams 6:40aM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2255 Pentland Drive Baltimore | Nonths | Days | Hours | Min. | Nonth | Days | Hours | Min. | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | Nonth | 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) MD • 5. Social Security Number 6. Sex **Funeral 1** M 2□F Months 71 Director 144-42-9439 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at show 1 X Yes 2 □ No Directo MD. Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 3 any Injury or other traumatic event, the Medical Examiner must be n 2255½ Pentland Drive 21234 by Funeral USA. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Auto Mechanic Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marshall Williams Williams 2 Elsie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deboronne Brown (daughter) 688 McCormick Dr, Tom River N.J. 08753 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 13Sept, 2007 Catonsville, Md. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Ser, PA.
1300 Eutaw Place, Baltimore, Md. 21. Signature of Funeral Service License 100875 2121723a. Part. Enter the diseas or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or his rt failure. List only one cause on each line. Approximate Interval Between Onset and Death LIVER Immediate Cause (Final CANCER uknown **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy In the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 Outrier (Specify) 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural (Month, Day Year) Injury 5 Pending To the Hospital or Attendis within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

ULLAAMS

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Lendall R taulkner MD/

alller

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D25643

555 W. Tousautown Blod/Bacto MD 21204

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day William E. Yunkun 18 2007 5:28 p September 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8268 Imperial Drive Laurel Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1**X**M 2□ F 59 207-36-5840 SEP 25 1947 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Prince George's Laurel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8268 Imperial Drive 20708 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗷 No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) $\overset{\text{Elementary/Secondary }(0\text{-}12)}{12}$ College (1-4or 5+) Voice Command NASA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Yunkun Margaret Hritz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine R. Yunkun - wife 8268 Imperial Drive, Laurel, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 9/19/2007 Baltimore, MD 21. Signature of Funeral Service Leansee H. Williams 22 Change and Address of Facility of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 4 WMONGW4 disease or condition resulting in death) YR Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 4□Pregnant at time of death Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or dical Examiner must be

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ratur any injury or other traumatic event, the Medical ange."

Director

Funeral

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Be Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed burial-transit and P.O. Box 68760, attending physician for use as the buria the detached þ Division or Vital Records, page 2 s certificate l this

Examine Physician/Medical Şq Completed မ Certification: filled in by the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

> 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

27. Manner of Death 5 ☐Pending investigation 1 Natural 2 Accident

6 Could not be determined 3 ☐ Suicide 4 Homicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Baltimore Ms

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

(Check only one) 29b. Signature and title of certifier

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Mudenberg

2007

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Month Day, Year) 22 S. Greens st 32 Registrar's Signature

State Registrar

Medical

DHMH 17 Rev 1/2001

After t

To the Hospital or Attending Within 24 hours after death.

To the Funeral Director: After

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Eloise J. Zeiger 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Pay, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral March 27, 219-01-0761 91 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Maryland Baltimore Director 1 ¥Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2919 Bayonne Avenue 21214 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify. 3 ₩ Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christian Krug Jeanette Plitt 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Zeiger / Daughter 2919 Bayonne Avenue Baltimore Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important; If it any injury or conce, 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Oak Lawn Cemetery 9/20/07 Baltimore Maryland 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc Baltimore Maryland 21214 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NOXIC disease or condition resulting in death) Due to (or as a consequence of): ARDIAC Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2K No Other: 4 Nursing Home Hospital: 1 Yes 2 ER/Outpatient 3 DOA 2 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Physician /Medical Examiner The law requires that the death certificate be executed P.O. Box 68760,

Department of Health item 27 other t

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

28a-f show

use as the burial-tran physician attending for

signed by the a d be detached for ate has page 2 s certificate

Division or Vital Records,

Certification:

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p

Medical

State Registrar Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

4 Homicide

29a. Certifier

WIDS

31. Date filed (Month, Day,

29b. Signature and title of certifier Emerism's

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOMEUS M.D.

2007

32 Registrar's Signature

GOOD SAMARITAN HOSPITAL

O051024

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 200Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Dav Month Yeer **Physician** Allen Martha September 6, 2007 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Silver Spring Montgomery 3377 South Leisure World Blvd. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 8. Month, Dey, Yea 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 M 2 XF Virginia 1916 Director 577-01-5129 91 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County in then "nature!", or items 23s or 28s-f show the Wedical Examiner must be notified at 28a-f show 1 ☐ Yes 24 ☐ No Completed by Funeral Director Maryland Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3377 South Leisure World Blvd. 20906 USA death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiene. and I feel and I 1 Never Married 2 Married 1 Tyes 2 No. Specify: SpecifiWhite 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Be Ada Pitman Joseph Marston 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4503-C Hazeltine Court, Alexandria, VA 22312 19a. Informant's Name/Relationship (Type, Print) Judith McBride/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Department of h Important: If ite sny injury or otl 9, Sept. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. School L. K. len 500 University Blvd, W. Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arteriosclerotic Cardiovascular Disease Years resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of? Physician/Medical Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 99 3 Probably 4 Munknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\times \) Yes \(2 \times \) No 24a. Was an autopsy performed? page , 1 TYes or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide within 24 hours a filled To the Hospitel 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D15236 September 7, 2007

20

Baltimore. Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records.

SEP 1 0 2007 State Registrar

11125 Rockville Pike, Rockville, MD 20853 Carl I. Margolis, M.D 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of Maryla		artment of H			iene eg. No. 2 N N 7	20200
F.	Physic	an	Decedent's Name (First, Middle, La Irving	st) Scott		they		Date of Deat Month	h Day Year	3. Time of Death
	/Medi		4a. Facility Name (If not institution, giv			·	or Location of Dea		er 2, 2007 4c. County of Dea	
			10706 Cash Valle			LaV			Alleg	any
	Funeral Director		214-20-0990	Sex 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) Co	hplace (State or Foreign buntry) 'Yland
	land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Mary a-f she	tor	MD Alle	gany		LaVale				1 ∐Yes 21∏ No
	with the	Il Director	10e. Street and Number 10706 Cash Val	ley Road		10f. Zip Code 2 1 5 0)2	1	0g. Citizen of What Co USA	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23a or 28a-f show any Injury or other traumetic event, the Medical Examiner must be notified et once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 Mayes 2 No 10 If Yes, Give Year or Dates: 10	u.s. 13. 952 –	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	dispanic Origin? (san, Mexican, Pue	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify:	e, etc.
9	2 hou natura ical E	ted	15. Decedent's E	ducation	I 16a. Dece	dent's Usual Occup	pation	1	W] 16b. Kind of Business/	nite Industry
218	ithin 7 ne. nen "r e Med	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire		rking		
d 21	Hygiel Hygiel ther ti	S	12 17. Father's Name (<i>First, Middle, Last</i>)	Se	erviceman		me (First, Middle, M	Petro]	Leum
Maryland 21215-0036	Aental rked o	To Be	Irving	Winfield	Athe	у	Bertha		Louella	Felton
lary	2 shou and N is ma is ma		19a. Informant's Name/Relationship (,	1				City or Town, State, 2	
	1 and Health em 27 ther tr		Mildred Athey / Wi						ale, MD 2	
nor	Pages ent of nt: If It		1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Inemoval from State		esition (Name of matory or other place Mem. Gar	i i		LaVale, 1	,
Baltimore,	permit. F Departm Importar any Injur		21. Signature of Funding Service Licer		2	2. Name and Addre	ss of Facility Ac	ams Famil		Home, P.A. 21502
	*		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a _Arterioscl	crotic	Heart Di	sease			Onset and Death Unknown
1	/Medical Examiner		Testing in death)	Due to (or as a conse	quence of):					
5,		ner	Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or injury that initiated events	b Due to (or as a conse	quence of):					
	ate be executed thysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	be ex sician burial	alE		Due to (or as a conse	quence on:					
9	th of	edical		d						
.O. Box	requires that the death certificaten signed by the attending plandid be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregi 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of del Month	ivery Day Year
Δ.	s that I		Part II. Other significant conditions of	contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Records,	w requires to been signer should be a	Completed by	Carcinoma of F	rostate				1 □ Ye	s 2 No 3 Pr	obably 4 XUnknown
Seco	law as b 2 s	nple						24a. Was ar autops	y prior to o	topsy findings available completion of cause of
aiF			25. Was case referred to medical					perform 1□ Yes 2	No 1 □Yes	2 □ No
or Vital	Physician; r this certific ral director,	o Be	examiner? 1 📉 Yes 2 🗆 No	Hospital: 1 ☐ Inpatient 2 [TER/Outpatier	it 3□ DOA Oth		ath (Check only one	nce 6 □Other (Spe	oifu)
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Division	or Attending after death. Director: After I in by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be		l ama farm atr		Yes 2 □ No	001 1 11 (0)		
Div	after of Direct of in by	Certification:	4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Spec	ify)	eet, ractory, onice		28f. Location (Sti City or Town	reet and Number or Ru , State)	ıral Route Number,
	To the Hospital or A within 24 hours after To the Funerel Directorpletely filled in by	edical C	29a. Certifier 1 ☐ Certifying Ph (Check only one) 1 ☐ Certifying Ph	ysician: To the best of my kn niner On the basis of examin and manner stated.	owledge, deat ation and/or in	n occurred at the tirvestigation, in my c	me, date and plac opinion, death occ	e, and due to the caurred at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	To th within To th сотр	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Monta	
	5/10A		DUK	p		D09	157		September	4, 2007
1	/		30. Name and address of person who Paul Snow, M.I				umberlan	d. Marvla	ınd 21502	
rips.	n & Sta	te	31. Date (SEP nt) Day, Year) 7	32. Registrar's Sign	ature /	_				
	Registr		AFL A # 5001	Beer S.	Good					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 0 0 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **L**onth 7006 Ronald Bridgeman 9:55 PM James 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Cheverly Prince GeorgesHospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Feb. 28, 1 Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 11 M 2□F 217-82-0707 38 1969 Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ZYes 2 No Maryland | Prince Georges Upper Marlboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20772 United States 9105 Washington Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Reginald Bridgeman, Sr. Dorothy E. Shorts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy E. Bridgeman / Mother 9105 Washington Ave. Upper Marlboro, Md. 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill 9/10/2007 Suitland, Md. 4 □ Donation 5 □ Other (Specify) 21. Sign of Funeral Service L 22,Name and Address of Facility Alexa Mariboro Pike/Forestville, Md. 20747 MOID w Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, by heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Findisease or condition resulting in death) Sepsis

Due to (or as a consequence of): hronic Obstructive Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3□ DOA

Physician /Medical **Examiner**

ppital or Attending Physician: The law requires that the death certificate be executed ours after death.

Beral Director: After this certificate has been signed by the attending physician and filled in by the unteral director, page 2 should be detached for use as the burial-transit

Completed by

Be

Certification: To

Medical

Division or Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

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Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examiner Physician/Medical IF FEMALE:

25. Was case referre examiner?	
27. Manner of Death	
1 Natural	5 Pending

Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b. Signature

2 Accident

3 ☐ Suicide

4 ☐ Homicide

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D055220

29d. Date signed (Month, Day, Year)

epleted cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year, Cheverly 3001 HOSP Dr Matin 32. Registrar's Signat

State Registrar

To the Hospital within 24 hours a To the Funeral

		Ear	Plea										I I Copi Iental I		-	ible.		
	•	FOI							rtificate of Death					Reg. No. 2007 30390				
Dhysisi		1. Decedent's Name (First, Middle, Last)							2. Da					e of Death oth Day Year			3. Time of De	ath
Physicia /Medic		ALBERT BABER							AUGU					T 3	0 :	2007	2230	М
Examin	er	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital							4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgome					
Funeral Director		579-36-4780 1\2 M 2□F				7. Age <i>(l.</i>		ast birthday Yrs.	Months	1 Year Days				Birth Day, Ye	ear) L934	9. Birthplace (State of Country) Washington		
and w		Usual Residence of Decedent 10a. State 10b. County				10c. City, Town or Location				ation						10d. Inside City Limits		
Manyl f sho ied al	ō	DC					T.	lachir	ngton								1 ★]Yes 2[
r 28a-	irec	10e. Street and Number					10f. Zip Code						10g.	Citizen of	What Co	untry?		
th with	Funeral Director	5147 7th St. N.E.							20011						U			
ems a	ner					dent Eve	r in U.S	S. 13.	. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					No-		ace - Ame	rican Indian,	
urs after ai", or it Examine	β	1 ☐ Never Marr 3 ☐ Widowed		ried	d 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates:				1 ☐ Yes 2 ☒ No Specify:						Spec		Black	
72 ho natur ileai	sted	15. Decedent's Education (Specify only highest grade completed)						16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)					ina	161	. Kind of I	Business/	'Industry	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4or 5-12th						Postal Clerk						US	US Post Office			
al Hy al Hy I othe	Be	17. Father's Name (First, Middle, Last)							18. Mother's Name					ne (First, Middle, Maiden Surname)				
Duld b Ment arkec aric e	인	Ollie Baber								Ellen Worthan								
2 short and raum		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number)										or Rural Route Number, City or Town, State, Zip Code)						
1 and Health em 27 ther t		Shirley		er/Wi	.fe	1	20h Pla		7th				ngton, Date				Town State	
Pages nent of I ant: If its ury or o		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or T Magning 20c. Location - City or T																
permit. Departr Importa any inji		21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, DC 20011																
		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												on.				
Physician		Immediate Cause (disease or condition									Onset and Dea 9 years	ath						
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 bours after death. within 24 bours after death certificate has been signed by the attending physicial To the Funeral Director. After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medica	23b. Was decedent pregnant in the past 12 months?							B⊟Ectopic pregnancy B□ Other (specify)						23d. Date of delivery Month Day Year			ır
s that ned b e deta	by Pł											ntribute to	the cause of deat	h?				
equire en sig ould b	ed b	Chronic Obstructive Lung Disease								1[☐ Yes 2☐ No 3☐ Probably 4 X☐Unknown			
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ian: rtifica ctor, p	Be C	Hypertension 25. Was case referred to medical examiner?								1 ☐ Yes 2X No 1 ☐ Yes 2X No 26. Place of Death (Check only one)								
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al or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office 28f. Lo										Location (Street and Number or Rural Route Number, City or Town, State)						
e Hospita 124 hours e Funera letely fille	Medical C	29a. Certifier (Check of by one) 29a. Certifier																
To th withir To th comp	Me	29b. Signature and title of certifier							29c. License number 2					29d.	29d. Date signed (Month, Day, Year)			
		· Carn							D28656 Se					Se	eptember 4, 2007			
(18)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi, MD 8609 Second AVe, #404B Silver Spring, Md. 20910																
Sta	te	31. Date filed (Mon							כ עד-	TT / E	- 2h1	TILE	114.	~ U J I	-			
Registr		SEP 0		he	32. Re	D.	Sp	es.										

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			For State Registrar	State o	of Maryla	nd / Depa	artment of H rtificate of	lealth and <i>Death</i>	Mental Hy	giene Reg. No. 20	07	30392		
	Physici /Medic		Decedent's Name (First, Middle	2. Date of Do Month	Death Day Year Sep 2, 2007		3. Time of Death 0507 M							
	Examin	er		give street and nu n Adventist H		4b. City, Town, or Location of Death Takoma Park			4c. County of Death Montgomery					
В	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. (Month, D	rth ay, Year) 25, 1943				
e, Marylan	laryland show	Director	Usual Residence of Decedent 10a. State 10b. County MD	Calvert	10c. C	ity, Town or Lo	ocation	Owings		10d. Inside City L 1				
	with the N a or 28a-f be notified		10e. Street and Number 115 Skinners Turn Ro			10f. Zip Code	Owings 20736		10g. Citizen of What Country? U.S.A.					
	d within 72 hours after death with the Marylar ginen '12 hours atten' '1. Then '1. The Medical Examiner must be notified at the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:				Was Decedent of H If Yes, specity Cub 1 ☐ Yes 2 [X](No		(Specity Yes or North Rican, etc.)	0- 14. Race Black	14. Race - American Indian, Black, White, etc. Specify: Black			
	within 72 hou ene. than "natura he Medical E	Completed I	15. Decedent (Specify only highes Elementary/Secondary (0-12)	1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						nd of Business/Industry Construction			
	be file ntal Hy od othe event,	To Be Co	17. Father's Name (First, Middle, I	Last)	Booth		Concre			me (First, Middle, Maiden Surname) Rebecca Wills				
	2 shou and M is mar raumati	F	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Michele Crawford /Daughter 1404 Adams Drive Fort Washington, MD 20744									Code)		
	Pages 1 a nent of Hea nt; If item iry or othe		20a. Method of Disposition 1 X Buria! 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State 20b.		osition (Name of matory or other place) UMC Cemete	! .	Date 09/08/07	20c. Location - C	City or Tov	,		
Dall	permit. Pag Department Important: any injury o		21. Signature of Funeral Service I	licensee Sewell	/		2. Name and Addre Sewell F	ss of Facility uneral Hom		Frederick, M				
A.	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. C. C. C. C. C. C. C. C. C. C. C. C. C											
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	w requires that the death certifice been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 ☐ Fet nant at time of	aldeath 3□	Ectopic pregnance Other (specify)	/		23d. Date of delivery Month Day Year				
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	The law re ate has bee page 2 sho	Be Completed			(<u> </u>			- auto	4a. Was an autopsy findings available prior to completion of cause of death? ☐ Yes 2 ☑ No				
	sician: certific rector,		25. Was case referred to medical examiner? Hospital:											
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date (Mon	-	28b. Time of 28c. Injury at 28d. Describe how injury occurred)		
	al or Atter s after dea al Director ed in by the	Medical Certification:	3 Suicide 6 Could n 4 Homicide determin	and Zoe. Place	of injury - At hing, etc. (Spec	l nome, farm, str ify)	eet, factory, office		28f. Location (ation (Street and Number or Rural Route Number, or Town, State)				
	the Hospit in 24 hour the Funera		29a. Certifier (Check only one) **Text Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	with Com.	29b. Signature and title of certifier 29c. License number 29d. Date signe 29d. Date signe									d (Month, Day, Year)			
	515		30. Name and address of person v	1. MO	U		Print) 7600 Takor	carro na Pai	11 AVe.	20912	2_			
	Sta Registr		SEP 7 2007	32. F	Registrar's Sign	party)			,					

State Registrar 31. Date filed (Month, Day,

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1 Executive Park Ct, Germantown, MD 20874 M,D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** onald)ep 200 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner of Maryland Baltimore Med. Levit If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 29, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 69 Maryland 212 36 1476 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 Yes 2 No Directo Anne Arundel Glen Burnie MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21060 United States 154 F Hammarlee Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ∏ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Virginia Virts Piercie John Bray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 805 Edisto Court Myrtle Beach, SC 29588 Naomi J. Morris/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 9-10-2007 | Elkridge, MD Meadowridge Mem. Pk. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Intracerebral nemorrhage **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Be Completed been 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? Director: After this certificate 2□ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes the funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred (Month, Day Year) Injury 1 MNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St. 1-dam 01 Douth 31. Date filed Month, Day, State 1 0 2007 Registrar DHMH 17 Rev 1/2001 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#23a, Lineb, perPHYS. G871 9/21/07 WS

State of Maryland Department of Health and Mental Hygien 2 0 7 30395 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 08:30 A M Beatrice Wagoner Burkentine 2007 Sep. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harkord Months Days Hours Min. 8. Date of Birth (Month, Day, Year)

April 14, 1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F 214-20-8461 86 Yrs. North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 X No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1719 Chapel Rd. 21078 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Uhite 1 ☐ Yes 2 🔀 No Specify: 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker Home. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Wagoner Beulah Wagoner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Revolution St. Apt 610 Havre de Grace, MD 21078 Ruth B. Collins (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Gardens 09/06/2007 Aberdeen, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Bellman Mitchell Smith Funeral Home 123 S. Washington St. Havre de Grace, MD 21078 23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio pulmonary

Due to (or as a consequence of): Arrest Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 10 years Due to (or as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mooths?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death Check only Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ≥ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: Let the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinus. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number P 006398 1 30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

Remain Lee, MD 669 Revolution St. Havre de Grace, MD Z 1078

State Registrar

Physician

/Medical

Examiner

Funeral

Director

iteme 23s or 28s-f show

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Pages 1 and 2 should be nent of Health and Mental

permit. Pages 1 and 2 Department of Health a Important: If Item 27 le any injury or other trat once.

Physician

/Medical Examiner

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Certification:

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Division of Vital Records,

death

within 24 hours after To the Funeral Dire

the Hospital

Completed by Funeral Director

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 30396 State of Maryland / Department of Health and Mental Hygiene? [] [] 7 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** AM Brandick 6100 Sep 2007 William /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Salubury

Salubury

Vaar If Under 24 Hrs.

Min. Wiconico Anchorage Nursing + Rehab If Under 1 Year Months Days Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months ™ M 2□ F 188-20-8615 81 Director 8/31/1926 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f ehow r then "naturel", or items 23a or 28a-f ehov tre Medical Examinar must be notified at 1 □ Yes 2 X No Pittsville Directo Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21850 8069 Gumboro Road 12. Was Decedent Ever in U.S. Armed Forces? 1 [★/es. 2 □ No If Yes, Give Year or Dates: Army 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify white δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Harris Inc. micro electronics 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 12 should be f h and Mental } is marked (unknown) Susan George Brandick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2:
Department of Heelth ar
Importent: If Item 27 is
eny Injury or other trsu 8069 Gumboro Rd., Pittsville, MD 21850 Blanche Brandick/wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Florida Memorial 9/10/07 Rockledge, FL 4 ☐ Donation 5 ☐ Other (Specify) Gardens 21. Signature of Funeral Service Licenses Name and Address of Facility Holloway Funeral Home Professional Association Certe 501 Snow Hill Rd., Salisbury, MD 21804 Levery 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerot **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate has been signed by the ettending physician end irector, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the deeth certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 🛮 No of Vital funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Placy of Death (Check only one) Other: 2 No 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗆 Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Magner of Death 28b. Time of After 1 D Natural 5 Pending investigation efter death.
I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospital
within 24 hours e
To the Funeral C
completely filled Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 00063991 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANUPAMAVARADARAJAN Spusory ios tipes mg

Registrar

State

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

07-07192	
Kenneth Burnette	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

enneur burneu		State of Maryland / Department 1- For State Registrar Certificate			eg. No. 200	7 3039
Physicia Medical Exami	in/	Decedent's Name (First, Middle,Last)		2. Date of Deat Month Septembe		3. Time of Death 0417 hrs
at.		KENNETH TYRONE BURNETTE, JR. 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death	
		John Hopkins Bayview Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore	Les IO Date of Bird	th(MM/DD/YYYY) 9. Bir	th-1 (01-1
Funeral Director			Months Days Hours M		Foreig	
any		10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
l (f ne Maryland or 28a-f show Ged at once,	ţō	MD PRINCE GEORGES LAUREL		51		1 X Yes 2 No
or 28a	Director	10e. Street and Number 8611 LOCUST GROVE DRIVE	10f. Zip Code 20707	, _ 10	Og. Citizen of What Cou UNITED STA	
death with the Maryland or items 23a or 28a-f sho	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (- 14. Race - Amer	can Indian, Black,
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Fun	1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	White, etc.	יי
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-003 d withii	Com	12TH WAR	EHOUSE SUPERVISOI	R ne (First, Middle, N	PRIVAT Maiden Surname)	E
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner	Be	KENNETH TYRONE BURNETTE, SR.	SHARO	N WARD		
MD 2. d 2 should th and M. n 27 is ma	٤		iling Address (Street and Number of CARLOUGH ST. CA		Diber, City or Town, State	
Te, N I and 2 Hearth Fitem 2		20a. Method of Disposition 20b. Place of Dis	position (Name of cemetery, other place)	Date	20c. Location - City or	
Baltimore, permit Pages I ar Department of Hee Important: If ite		Table 2 Granding of Removal non-State	MEMORIAL PARK 09	9/22/07	LANDOVE	R, MD
Baltimore, MD 21 pernit Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er		27: 6ignature of Funeral Service Licensee	MARSHALL'S FUNERA 4308 SUITLAND ROA	AL HOME (OF MARYLAND TLAND, MD 2	, INC.
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Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Medical	X unpended X amended #1,23a,27,perME,g872,	10/3/07 TT			
876C tificate ng phys		23b. Was decedent pregnant in the	Fetal death 3 Ectopic preg	inancy	23d. Date of deliver Month	y Day Year
OX 6 ath cer	Physician/	past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			,
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Records, The law require ficate has been si , page 2 should b	Completed			24a. Was autop		topsy findings available completion of cause of
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical	26.Place of Death (Chec	1 ✓ Yes		es 2 No
Vita tysician this cer	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpati			Residence 6 Othe	
1 of ling Ph After t funeral	J: L	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time		28d. Describe	now injury occurred	
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Div pital or ours after after after in	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, S		,
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fineral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the bast of my knowledge, death or one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.				
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mo	
		30. Name and address of person who completed cause of death (Item 23a)				
2			reet, Baltimore, MD 21201			
Sta Regist	ate					

Physician /Medical Examiner

Physician

/Medical

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Director

Funeral

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Completed

Be

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

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Ĭ	resulting in death) Last	Due to (or as a conseq	uence of):				
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2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna				23d. Date of de	livery
S S	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		c pregnancy (specify)		Month	Day Year
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7	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlyin	g cause given in Part I.	23e. Did tobaco	co use contribute t	o the cause of death?
6	HYPO ALI	BUMENEMIA	2		1 □ Yes	2□No 3□P	robably 4 Onknown
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					24a. Was an autopsy	24b. Were a prior to	utopsy findings available completion of cause of
3					performed 1∐ Yes 2 🖸		s 2□No
0	25. Was case referred to medical examiner?				eath (Check only one)		
0	1 Ves 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 Residence	e 6 ⊟Other (Spa	ecify)
OU:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how i	njury occurred	
gal	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		М	1 ☐ Yes 2 ☐ No			
Certification:	4 Homicide determined	28e. Place of injury - At ho building, etc. (Specif	ome, farm, street, fact y)	tory, office	28f. Location (Stree City or Town, S	t and Number or R tate)	ural Route Number,
Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysiclan: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occurr ution and/or investigat	red at the time, date and plation, in my opinion, death of	ce, and due to the caus courred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
ž	29b. Signature and title of certifier		:	29c. License number	29d.	Date signed (Mon	th, Day, Year)
	Paya	MD		D00509	5/	8/31/6	57
	30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Print)				

State Registrar

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31. Date filed (Month, Day, Year)

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KENILWORTH

32. Registrar's Signature

RIVERDALE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 () () 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Frank Clark 09 08 07 2017 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WMHS Braddock Campus Allegany Cumberland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X** M 2□ F 212-94-1908 40 Maryland Director November 22, 1966 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 XYes 2 □ No Directo Maryland Allegany Frostburg 10e. Street and Number 59 Linden Street 10f. Zip Code 10g. Citizen of What Country? 21532-U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Completed by It Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) not employed not employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **Edward Clark** Martha Lee Davis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Clark brother Frostburg Maryland 21532-59 Linden Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Cumberland Crematory** September 09, 2007 Cumberland Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1∐ Yes 2 🗆 Kio To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 □ DOA 1 Inpatient မှ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I completely filled Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: In the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manus stated. (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D36766

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State Registrar itram ad

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

m.p.

32. Registrar's Signature

Seton Prove Camperland, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 1 1 2007

Poonai

State of Maryland / Department	of Health and Mental	Hygiene2	00) "

30401 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 **Physician** Collins Sept. Ernest 1603 L. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Center Cheverly Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 22, 1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🕱 M 2 🗆 F Director 579-16-6928 82 Wash., DC Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "natural", or Iteme 23a or 28a-f show traumatic event, the Medical Exacitment cust by notified at 1 XYes 2 No Director Md. Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2647 Shadyside Ave. #T2 20746 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1⊠Yes 2 No 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1943-1 ☐ Yes 2 X No Specify: as Giva Specify: Black ۾ lf Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 1945 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Manager Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Waley Jackson ပ Ruby Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2647 Shadyside Ave 107.6

20b. Place of Disposition (Name of cometery, crematory or other place) Doris Collins/wife Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cem. 9/10/07 Md. Cheltenham, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 23a. Party Enter the disease, or complications that daysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3910 Silver Hill Rd., Suitland, Md. 20746 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Examiner death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical as IE EEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) P.O. I detached the 9 Unknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 ☐ Yes 2 ₺ No 1□ Yes 2 No Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 MEP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident the 1 within 24 hours after death To the Funeral Director: 6 Could not be determined 3 T Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗍 Homicide Pelli the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and a trains of person completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signat 31. Date filed (Month, Day, Year) State SEP 0 7 2007 Registrar

07-06781 Daryl Crutchfield

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 30402

,			1- For State Certificate of De	ath	Reg.	No.
	Physicia	ın/	Decedent's Name (First, Middle,Last)		Date of Death Month	3. Time of Death
VI-	"∽al Exami	_	DARYL ANTHONY CRUTCHFIELD		September	1, 2007 0407 111S
			Table (in the the tree of green of the tree of green of the tree o	ity, Town, or Location of Death ver Spring		Montgomery
	Funeral		J. Social Security Harrison	Under 1 Year If Under 24Hrs	_	(MM/DD/YYYY) 9. Birthplace (State or Foreign
	Director		216-/2-16// 1XM 2 F 48 Yrs.	onths Days Hours Min	Sept.	6,1958 Country) MD
	any:		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	A .	١	MD Montgomery Silve	r Spring		1 Yes 2X No
	larylaı 28a-f	Director	10e. Street and Number 10f.	. Zip Code	. 10g	. Citizen of What Country?
	th the Maryland 23a or 28a-f sho notified at once.		13207 Osterport Drive	20906	farði	U.S.A.
	th with	Funeral		cedent of Hispanic Origin? (S pecify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
	after death with the Maryland al", or items 23a or 28a-f sh iner must be notified at once		1 Yes 2 No	2 X No specify:		Specify: Black
***	urs aft	d by	or Dates:	sual Occupation (Give kind of		16b. Kind of Business/Industry
	72 ho	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	f working life. DO NOT use ret		USPHS - US Coast Guard
	5-0036 Thed within 7 Hygiene. I other than	E E	5+ Public	Health Off	First, Middle, Ma	
		Be C	17. Father's Name (First, Middle, Last) Wellington Crutchfield, Sr		oanne H	
	D 2121 should be fi and Mental 7 is marked	To B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add			er, City or Town, State, Zip Code 20906
	MD nd 2 sho atth and m 27 is aumati		Charlotte Crutchfield (Wife) 1320			
	re, ME s 1 and 2 s of Health at If item 27		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Crutchfiel	(Name of cemetery, lace)		20c. Location - City or Town, State
	Pages 1	E				Rockville,MD
	Baltimore, Moemit. Pages 1 and 2 Department of Health Important: If item 2 Injury or other trajur	74				UNERAL HOME, P.A. ockville, MD 20850
	Physician	4	23a. Part I. Enter the disease, or complications that caused the due th. Do not enter the mo			st, shock, or heart Approximate Interval
P	Medical		failure. List only one cause on each line.	. •	,	Between Onset and Death
-	xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	1.575		
		١	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):			
		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
	ed nsit	Exar	events resulting in death) Last Due to (or as a consequence of):			
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	760, Icate be physicial the buria	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
	687 ertific iding p	sician/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal de		ancy	Month Day Year
	Box 687 e death certific the attending perfect of the attending perfect	ysic	1 Yes 2 No 9 Unknown Pregnant at time or death 5 Other 9 Unknown	(Specify)		
	Records, P.O. Box 68' The law requires that the death certiff cate has been signed by the attending page 2 should be detached for use as i	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.		pacco use contribute to the cause of death?
	ires the signer is signer is the de	d by				2 No 3 Probably 4 Unknown
	w requires been shoulk	plete			24a. Was a autops perform	y prior to completion of cause of
	Reconstant The land	Completed			1 ✓ Yes 2	
	of Vital Recoing Physician: The law After this certificate has uneral director, page 2 s	Be C	25. Was case referred to medical	26.Place of Death (Check		Residence 6 🗸 Other: Scene
	f Vi Physi er this	To	1 Ves 2 No 1 Inpatient 2 ENOutpatient 3	201	3	ow injury occurred
	nding ith.	ion:	1 Natural 5 Pending Sep 1, 2007 0330 hrs	1 Yes 2 ✔ No	Driver auto o	collision
	Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	2 ✔ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fa	actory, office building, etc.	28f. Location (S or Town, St	treet and Number or Rural Route Number, City
	Division of pital of purs after all Division of Filled i	Serti	4 Homicide determined (Specify) Local Street		George Avenu	e & Noyes Drive, Silver Spring , MD
	Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page			at the time, date and place, an in my opinion, death occurred	d due to the cause at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
1	5	_	MITTO -	O.C.M.E.		September 1, 2007
			30. Name and address of person who completed cause of death (Item 23a)	<u></u>		
			Ana Rubio MD. Assistant Medical Examiner 111 Penn Stre	et, Baltimore, MD 2120)1	
		tate	DEF = 7 / / / / / / / / / / / / / / / / / /	A i		
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Ľ	HMH 17 Rev 1/3	∠∪U1	ORIGINAL			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 30403 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1)onna L. Conway 1206 PM 09 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Worcester Atlantic General Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 4-19-1955 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Yrs. 214-64-9155 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h Count 10d. Inside City Limits 28a-fehov 1 ☐ Yes 2 X No Director MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 10132 Waterview Dr. 21842 USA iteme 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō Specify: USA 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ie marked of Joseph F. Conway Doris Marks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth a Important: if item 27 ie eny injury or other traigne. 101003 Grays Corner Rd. #49, Berlin, Md. 21811 Mark Conway (brother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2☐Cremation 3 ☐Removal from State Sept.9,2007 Frankford, DE Cape Henlopen Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Seizure Idisorder **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, and, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ೭ಳ ೭/೯೯ ಅರ್ ಶ Hepatic Encephalopathy 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform rmed? 2 A No certificate 1 ☐ Yes Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Division of this After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 9 within 24 hours at To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) ÷ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ~, mD. 30. Nam address of person who completed cause of death (Item 23a) (Type, Print) 9714 Healthway Drive, Berlin mD 21811 pf 20 Glenn K. Aradon, MD 31. Date filed (Month, Day, Year) 32. Pogistrar's Signature State SEP 1 0 2007 Registrar

Dan

			For State Registrer	State of I	Marylan	d / Depa		of He	alth a		•	/giene	2007	301.01
	^q Physici	an	Decedent's Name (First, Middle, PA-(1) Company of the compa	Last) ALLE	= 1/ >						2. Date of D Month		Z O O Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution,				4b. City, Tov	wn ort	ocation o	f Death	4 1	4c.	County of Dea	1 - 421
	Examin	er	Ellicott City N				-		t Ci				Howard	
	Funeral				Age (In yrs. i	last birthday)	If Under 1 Y	ear	If Under 2	24 Hrs.	8. Date of Bi	rth		rthplace (State or Foreign country)
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920	urs al	by	3 Widowed 4 Divorced	If Yes, Give Year or Date			1□Yes 2🔯	No	Specify:				Specify:	White
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nd	d oth	Be	17. Father's Name (First, Middle, L								(First, Middle		Sumame)	
<u>Y</u>	should be filed within nd Mental Hygiene. : marked other than amatic avent, II e. M.	၉	Donald W. Calle								Scalera			
Maryland	12 sho h and 7 is mu treuma		19a. Informant's Name/Relationsh Beth Callender/			1	ng Address (St					-	Town, State,	Zip Code)
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	THE REAL PROPERTY.		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that cau	sed the death								Ĩ.	Approximate Interval Between
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Вох	eath certifica attending ph for use as th	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								2	3d. Date of de	elivery
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Division	I or Attendi after death. Director; A I in by the fu	Certification:	4 Homicide determin	building,	etc. (Specify	()	eer, ractory, or	1100				wn, State)	rvamber or r	was route rumber,
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(10	2)22		30. Name and address of person w	mo completed cause	of death (Item	23а) (Туре,	Print)	EV	WE	TH	Gil	EHZ	MIS	701
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physic /Medi		Frances	Hayden		rowder				09	02	2007	08:30 A
Exami	ner	4a. Facility Name (If not institution	n, give street and numbe	15) A G	tro	4b. City, Tow	n, or Location			4	C. County of Deat	
Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs.	last birthday)	If Under 1 Y	ear If Und	lef 24 Hrs.	8. Date of B	irth		nplace (State or For
Director		563–18–4780	1 □ M 2 🕱 F	90	Yrs.	IVIORUIS DE	ays Hour	s Min.	8. Date of B (Month, D 4/25/	1917	Ca	lifornia
land ow		Usual Residence of Decedent 10a. State 10b. County	1	10c. Ci	ty, Town or Lo	cation			-			10d. Inside City Li
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or 28	Dire	10e. Street and Number				10f. Zip Cod				_	itizen of What Co	untry?
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e filed al Hygid other vent, th	BeC	17. Father's Name (First, Middle,	•				18. Mo	ther's Name	e (First, Middl			
2 should be filed withir nand Mental Hygiene. Is marked other than raumatic event, the Me	2	Franklin A. F							layden			
s 1 and 2 should be filed within 72 hd If Health and Mental Hygiene. Item 27 Is marked other than "natu other traumatic event, the Medi-al		19a. Informant's Name/Relations Hayden H. Gord				ig Address <i>(Sti</i> Box 45 ,					or Town, State, Z	ip Code)
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra	1 8	20a. Method of Disposition	,	20b. F	_	sition (Name o			Date		ocation - City or	Town, State
Pages nent of h int: If ite		1 ☐ Burial 2 Ix Cremation 4 ☐ Donation 5 ☐ Other (5				y Crema		9/5/	′07	Sa	lisbury,	MD
permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	Licensee	0	22	Name and Ad	dress of Fa	cility ral H	ome Pro	ı ofesi	sional A	ssociati
90 E # 9		Jerle 11	sture (ASO	3	OT PUO	A HITT	Ra.,	Salis	oury	, MD 218	04
		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complication, that cause t only one cause on each	ed the deat line.	th. Do not ent	er the mode of	dying, such	as cardiac	or respiratory	arrest,		Approximate Interval Betwee Onset and Dea
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. HUU	TE	KER	VAC	t	ALL	UNE			
Examiner			Due to (or a	is a conseq	quence or):							
₽ #	ner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Eue to (or a	is a conseq	uence of):							
ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a									
rificate be executed g physician and as the burial-transit	alE	,	Due to (or a	is a conseq	juence or).							
tificate ig phys as the	ledical		d									
eath cert attending for use	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne pf pregna		Ectopic pregna	ancy				23d. Date of deli	very
requires that the death cer een signed by the attendir nould be detached for use	Physician/N	in the past 12 months? 1 ☐ Yes 21 No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of d		Other (specify					Month	Day Yea
that the de ned by the a		Part II. Other significant conditi	ons contributing to death	but not res	ulting in the ur	nderlving cause	given in Pa	rt I.	23e. Did	tobacco	use contribute to	the cause of deat
uires n signe	d by	URINARY	TRACT	10	NFECT		3				No 3□Pro	
aw s b	Completed	ATRIAI	FIBRILL	ATI	INN				24a. Was		24b. Were au	topsy findings ava
sician: The law r certificate has be irector, page 2 sh	mo:	711=11							auto perl 1⊟ Yes	opsy formed? N	prior to c death?	topsy findings ava ompletion of caus
ysiclan: iis certifica director,	Be	25. Was case referred to medica examiner?		1				ice of Deatl	(Check only			y
Phy this aldi	၉	1 Yes 2 No	Hospital: Inpat		ER/Outpatien 28b. Time of	1 3 DOA					6 □Other (Spec	rify)
fune	ţi	1 ∠ Natural 5 □ Pendir 2 □ Accident investi	ng (Month, D	ay Year)	Injury		njury at Work? 1 ∐ Yes 2		28d. Describe	now inju	iry occurred	
Attend ar death. ector: / by the f	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of in	njury - At ho etc. (Specif	ome, farm, stre				28f. Location	(Street a	nd Number or Ru	ral Route Number
ital or rs afte rs afte ral Dir	Ser								City or To			
To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical	(Check only 2 ☐ Medical	ng Physiclan: To the bes Examiner: On the basis	of examina	wledge, death ation and/or inv	occurred at the	e time, date ny opinion, d	and place, death occur	and due to the red at the time	e cause(s	s) and manner as id place, and due	stated. to the cause(s)
o the ithin 2 o the omplet	Med	one) 29b. Signature and title of certifie	and manner s	stated.			ense numbe				ate signed (Month	
<u>6</u>		VIIIMA.	11/11/11		AAD	77-					9/2/10-	7
2.		30. Name and address of person	who completed cause of	death (Iten	n 23a) (Type, I	Print)		0513			1/2/0	
SI		M. THIMMI AR	AYAPPA	614	BE	ASTERL	1 5	HIKE	PR,	SA	LISISUKY	140218
		31. Date filed (Month, Day, Year)										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien20171 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Year 1400 OUDER 2007 /Medical 4b. Cily, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico SOUR If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) JULY 26, 1948 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**%** M 2□ F 15-56-5248 Director Del AWave Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event. The Medical Examinal must be notified at 1 ☐ Yes 2 ☐ No Be Completed by Funeral Director NICOMICO 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21 WAY 804 NE United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 You o
If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Disabled NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Cooper (france) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1944 SALISbury md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Parsons Lemeters Salisbury * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of acilit Bennie Smith 21. Signature of Funeral Sarvice Licensee FUNOral Home SABELLA St. S SALISbury, md 2180 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto for as a por sequence of Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physicien and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by now 1 ☐ Yes 2 ☐ No 3 Drobably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? 1 Yes 2 1 No 25. Was case referred to medical examiner?

1 Ves 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

29b. Signature and tille of

31. Date filed (Month, Day Year)

30. Name and address of person-who completed cause of death (Item 23a) (Type, Print)

100

2007

E

Carroll St.

32. Resistrar's Signature

29c. License number

salisbu

29d. Date signed (Month, Day, Year)

21801

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** September F., Creeger 2007 /Medical 4c. County of Death Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** EGIONAL MEDICAL CENTER Nicomico ENINSULA PALISBURY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F Director 97 067-01-2292 2-13-1909 <u>Maryland</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X ☐ No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 311 Brewington Drive USA 21801 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2**X** No ģ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (William Tregoning Mary Ethel Haifleigh ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G. Wayne Creeger - son 311 Brewington Drive, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Blue Ridge Cemetery 9-11-2007 Thurmont, Maryland 22. Name and Address of Facility 21. Signature of Euneral Service Licenses Bounds Funeral Home 705 E. Main Street, Salisbury, MD 21804 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ASCVD disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year signed by the at d be detached for 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2 **N**o To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۴ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of 29c. License number HO059368 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johan V131001 100 31. Date filed (Month 32. Registrar's Signature State 2007 Registrar

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 30409 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mabel E. Dove 9/6/2007 6:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Vindobona Nursing Home Braddock Heights Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 4/29/1922 Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖼 F Director 85 218-14-1021 Virginia Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show be notified at 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Md. Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6516 Jefferson Blvd. 21703 United States items 23a **Examiner must** Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 "natural", or White 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 0 12 should be filed w and Mental Hygier
7 Is marked other til 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev Rozier Embrey Maggie Gray ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce M. Hall / Daughter 6516 Jefferson Blvd., Frederick, Md. 21703 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) St. Luke's Cemetery 9/10/07 Redland, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home Barbe mure P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 Day preumonia /Medical Due to (or * a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) P.0. signed by the a ld be detached f 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown epart on 87 cm Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy page certificate 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Inpatient this After thi 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division Natural 5 Pending investigation fter dean ral Director Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours

To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State Registrar 29b. Signature and title of certifier

Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas

Hiren N

honson

State of Maryland / Department of Health and Mental Hygiene, For State Registrar 30410 Certificate of Death 1. Decedent's Name (First, Middle, Last)
Myrtle Luck Davis 2. Date of Death 3 Time of Death ^{Day} 2007 Yeer sept.5, **Physician** 8:25P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Clinton, Md. Future Care Health Facility P.G. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthp. Coun Dec. 10, 1916 Va. Birthplece (State or Foreign _ Country) Social Security Number 224-054768A 6. Sex **Funeral** Days Hours 1 ☐ M 2 🕱 F Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Marylar Heatth and Mental Hygiene.
em 27 is marked other than "natural", or Items 23a or 28a-1 show what traumalte event, the Medical Examines round to motified P.G. Md. Clinton 1 XYes 2 No Director 10e. Street and Number 9601 Pineview Lane 10f. Zip Code 20735 10g. Citizen of What Country? U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Black Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Private Families Elementary/Secondary (0-12) College (1-4or 5+) Domestic 18. Mother's Name (First, Middle, Maiden Sumame)
Hattie Wilson 17. Father's Name (First, Middle, Last)
Benjamin Luck Benjamin 19a Informant's Name/Relationship (Type, Print) Cordia M. Long- Sister 19b. Maijing Address (Street and Number or Rural Route Number. City or Town, State. Zip Code) 785 Number Ave. Hyattsville Md. 20785 permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any injury or other trau Baltimore, 20c. Location - City or Town, State Beltsville, Md. 20b. Place of Disposition (Name of 20a. Method of Disposition Chesapeake Crematory

Chesapeake Crematory 1 Burial 2 Cremation 3 Removal from State * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Robinson Funeral Home 1313 6th St. NW
Wash., D.C. 20001 21. Signature of Funeral Service Ouron du Approximate Interval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** S - quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): certificate be executed the attending physicien and hed for use as the burial-tran Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 s certificate 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Certification: To 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 5 Pending Injury 1 Natural 2 Accident s after death. 1 ☐ Yes 2 ☐ No investigation the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by determined 4 Homicide ŏ within 24 hours a To the Funeral Completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of Philip person who complete Wisotsky oleted cause of death (Item 23a) (Type, Print)

Ky 12070 Old Line Center Suite 207 Waldorf, Md SEP 0 7 2007 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Registrar

Philip Wisotsky, MD

31. Date filed (Month, Day, Year)

SEP 0 7 2007

32. Registrar's Signatur

12070 Old Line Center Suite 207

Waldorf, Md.

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	State of Maryland	/ Department of He	altii and Menta	iriygiche

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A Facility Name of the residuality, one since and number of Name of the Name o	liy3iciai.		Ser Land Condon David	otember 4, 2007
Sold Statish Native: C. See 7.49 (nr.ys. last brinder) 100.0 (b), tear of Lorenze 100.0 (b), tear	zxamme	4a	. Facility Name (if not institution, give street and number) Montgomery Village	Montgomery
The State 100 County 100 Coty Town of Location 100 C	neral ector	1	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. D. Months Days Hours Min.	ec. 9,1944 Foreign Washingto
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Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (o		+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or rec	Between Onset ar
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1	ned by the detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Yes 2 No 3 Probably 4 Vunknow
20+1 20+1 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	has been sig	npleted		autopsy prior to completion of cause death?
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30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		Medi	and manner stated. 29c. License number 29b. Signature and title of certifier	29d. Date signed (Month, Day, Year)
LING LI, WID 7 GOLDEN WEST	XUT (
State 31. Date filed (Mor StDD, Year), 2007 32. Figure 3. State 3. Signature 3. State 3. Signature 3. State 3. Signature 3. Signature 3. State 3. Signature 3. Si			Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, WD 21251	

Amend #3 Per Phy G8/2 10/04 JH Certificate of Death Reg. No. 30413 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Rudolf Delarosa 5:55p 31, 2007 /Medical August_ 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 205 Lakewood Drive Salisbury Wicomico If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F Director 573-49-0291 Yrs 62 4/9/1945 Phillippines Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Itema 23s or 28s-f show Maryland Wicomico Salisbury 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 235 Middle Blvd. 21801 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Maritaf Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after of Hygiene.

I Hygiene.

other than "natural", or Iter 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: Phillippino 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Efementary/Secondary (0-12) College (1-4or 5+) 12 Graphic Designer Commercial Artist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fi of Health and Mental H fitem 27 is marked off Rogelio L. Delarosa Carolta Delgado 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zip Code) Rodger Delarosa/son 857 S. Orange Grove Blvd., Pasadena, CA 91105 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite eny injury or ot once. 1 ☐ Buriaf 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 9/5/07 Salisbury, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HOIIOWay Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Keels 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Recurrent /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of): attending physicien for use as the buria Physiclan/Medical use as the Box 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) o. been signed by the should be detached 9 Unknown 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 4 Unknown 3 Probably Completed 1 ☐ Yes 2 ☐ No The law 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? this certificate 1 Yes 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Brothers 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manher of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide hours after within 24 hours a
To the Funeral I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 029283 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 145 E. Carroll St., Suite A-1, Salisbury, MD 21801 Dr. Jimmy Taylor Registrar's Signature 31. Date filed (NSTP) Pay(Year) 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30414 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** September 05 Hattie Jeanette Ennis 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Doctor's Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. March 19,1910 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months 220-40-7025 1 □ M 21 F 97 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MXYes 2 □ No MD Prince George's Lanham Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 6835 3rd Street USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White Specify: ğ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milo S. Rees Matilda Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9504 Tuckerman Street, Lanham, Maryland 20706 David Allen Ennis/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/8/07 Adelphi, Maryland George Washington Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 4739 Baltimore Avenue 22. Name and Address of Facility Gasch's Funeral Home, PA Hyattsville, MD 20781 has M01491 richille 23. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or s a consequence of): MAZULAIZ DEGENERATION Sequentially list conditions, if any, localing to finite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Director as a consequence of) Examiner CHIED PORO SIS Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examine 2 1 res 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: August 31, 2001 5 Pending investigation 1 Natural Injury 1230/M 2 Accident 1 Yes 2 No 6 ☐ Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Bural Route Number, City or Town, State) 535 35 57 Larham Many and determined 4 Homicide STre home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accounted at the cause(s) and manner as stated.

The law requires that the death certificate be executed sician and burial-trans Division or Vital Records, P.O. Box 68760, attending physician signed by t or Attending Physician: reral Director: /

Funeral

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

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permit. Pages 1 Department of H Important: If itel any injury or oth

Physician

/Medical Examiner

filed within 72 hours after death with the Maryland Hygiene.

Maryland 21215-0036

Baltimore,

To the Hospital within 24 hours a To the Funeral E

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of

07

Medical

32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MASURI

Alsto

7525 GREENWA

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D55550

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29d. Date signed (Month, Day, Year)

2072

SEPTEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2007 Clarice Erickson August 3:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sunrise Assisted Living Montgomery Village Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 TF Yrs. Director 501-03-3780 90 <u>April 22, 1917 Minnesota</u> Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show r 28a-f shov notified at 1 ☐ Yes 2√☐ No Directo Maryland | Montgomery Montgomery Village 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or edical Examiner must be 19310 Club House Drive # 325 20886 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: White 2 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Lead Office Worker Douglas Aircraft Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William F. Willer Clara Beito ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2282 Astoria Circle, # 104, Herndon, VA, 20170
pe of Disposition (Name of Date 20c. Location - City of Town, State Ralph E. Erickson- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Fort Lincoln Crematory Sept. 6, 2007 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brentwood, MD § ☐ Other (Specify) 4 ☐ Donation 21. Signature of Fureral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Rockville, MD 23a. Part1. Enter the disease, or complications that on sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Metastatic Breast Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Entail or unitying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the a page 2 should be detached to 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence ANOther (Specify) Assisted 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending

Saltimore, Maryland 21215-0036

State Registrar (Check only

31. Date filed (Month

29b. Signature and title of confier

Stephen Dolinsky, MD,

29c. License number

Avenue, Gaithersburg, MD 20879

D20148

29d. Date signed (Month, Day, Year)

September 5, 2007

and manner stated.

911 Russe11

32. Resstrar's Signature

30. Name and address of person who completed cause of death (Item 23) (Type, Print)

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** August 31, 2007 4:50 P M Ethel M. Elliott /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1203 Maple Street Wicomico Delmar If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛛 F Yrs. 83 Director 219-12-9255 11, 1924 Delaware Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. snt: if Itam 27 is marked other than "natural", or Items 23s or 28s-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State itam 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 XYes 2 No Directo Wicomico Delmar 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1203 Maple Street 21875 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify à Specify: white 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dietary Technician Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Laura Waller Edgar J. O'Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda E. Hastings (Daughter) 6901 Delmar Road Delmar, DE 19940 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of importent: if it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) St. Stephens Cemetery 9-5-2007 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home t. Delmar, DE Short Funeral H 13 E. Grove St. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fillure. List only one cause on each line. 23a. Part1. Approximate Interval Retween Onset and Death Immediate Cause (Pinal **Physician** denvolu /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 pronths?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy jo Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4. Onknown 1 ☐ Yes 2 ☐ No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 22 No certificate 1 ☐ Yes 2 ☐ No 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After this filled in by the funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation M 1 Yes 2 No 2 Accident Diractor: 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funerel [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 29c. License number MU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Hon 31. Date filed (Month, MO DN 15 Day. 32. Agistrar's Signature Year) State 0 5 Registrar

			and / Department of Health and Certificate of Death	
/M	siciar edica mine	Fannie McCrae Freeman	4b. City, Town, or Location of Deat	2. Date of Death Month Day Year August 29, 2007 6:30 A M
Fune Direc	ral	Heartland Nursing Home 5. Social Security Number 6. Sex 7. Age (In y 245-16-7785 1 M 2 NF 91	rs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	Prince George s 8. Date of Birth (Month, Day, Year) March 15, 1916 McColl, SC
death with the Maryland me 23a or 28a-f ehow			City, Town or Location Washington 10f. Zip Code	10d. Inside City Limits 1 □ Yes 2 □ No 10g. Citizen of What Country?
hours after turel', or ite	of by	3 Twidowed 4 Divorced If Yes, Give Year or Dates:	20019 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 Yes No Specify:	Decify Yes or No- o Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Negro 16b. Kind of Business/Industry
d be filed within 72 sental Hygiene.	Total Care	(Specify only highest grade completed) Elementary/Secondary (0-12) 8 years 17. Father's Name (First, Middle, Last)	(Give kind of work done during most of work life. DO NOT use retired) Silk Finisher	Private (First, Middle, Maiden Sumame)
s 1 and 2 should b f Health and Ment from 27 te marked		John Hines 19a. Informant's Name/Relationship (Type, Print) Annie L. Williams — Daughter	19b. Mailing Address (Street and Number or Rt 4921 - 7th Place, NE W	
permit. Peges 1 Department of H Important: If ite	5	1 St Burial 2 ☐ Cremation 3 ☐ Removal from State		ewart Funeral Home, Inc.
Physici /Medic	an cal	23a. Part. Inter the diseas, or complications that caused the dishock of heaf failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atheroscle a. Due to (or as a cons	eath. Do not enter the mode of dying, such as cardiac rotic Cardiovascular Dis	Interval Between
eath certificate be executed attending physicien and for use as the bruist transit	Evaminar India	d		
the death certificativy the attending phy	beM/deicial	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant at time of pregnant at	etal death 3 □Ectopic pregnancy	23d. Date of delivery Month Day Year
requires that sen signed by			resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
The far	omo	25. Was case referred to medical	26. Place of Dea	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No
Physic r this ce) F	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2		ome 5 Residence 6 Other (Specify)
After After	1	27. Manner of Death 1 Natural 5 Pending (Month, Day Year, 2 Accident investigation	28b. Time of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occurred
	ifical	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - A building, etc. (Spe	thome, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital or within 24 hours effer to the Funeral Director of the Funera	Madical		knowledge, death occurred at the time, date and place ination and/or investigation, in my opinion, death occu	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)
To the I	Me	29b. Signature and title of certifier Lucy M	29c. License number D0058290	29d. Date signed (Month, Dey, Year) September 7, 2007
Z (Y	1		arvis Avenue Suite 200 R	iverdale, MD 20737
Door	State		anaure de	

Facility Name (If not institution, give street and number) Examiner ENINSULA KEGIONAL MEDICAL CENTER ALISBURY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2 1 F Director 212-54-3811 61 Nov 30, Usual Residence of Decedent 10a. State 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 609 Baker St. Funeral 21804 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 → Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Cab driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Lee Johnson Daisy L. Johnson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Johnson/brother 713 College Lane, Apt. 4, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crematory of Delmarva 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/5/2007 21. Signature of Funeral Service License e 22. Name and Address of Facility Lewis N. Watson Funeral Home ialara to warson 1618 West Rd., Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myelogenous **Physician** Chronic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2. Registrar's Signature

James E. MARTIN

31. Date filed (Month SEP)

1. Decedent's Name (First, Middle, Last)

Eleanor Louise Fooks

Physician

/Medical

Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 2 K No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Sept. 4, 2007 030690

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007

Year

2007

Birthplace (State or Foreign Country)
 DC

10d. Inside City Limits

Approximate Interval Between Onset and Death

40005

11 Yes 2 □ No

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

20c. Location - City or Town, State

Delmar, DE

USA

14. Race - American Indian Black, White, etc.

Black

Transportation

WICOMIED

Day

1945

2. Date of Death Month 9

Registrar DHMH 17 Rev 1/2001

State

certificate be executed

attending physician

certificate has page 2

director,

funeral

filled in by the

After

24 hours after death.

within 2

Hospitai or Attending

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the

nse

Box 68760.

P.0.

Division or Vital Records,

145

E. Grail ST. Solisburg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend#26.PerME PGC 9-10-07cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Guy Green 1:42 p^M August /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 304 Loureiro Lane Oxon Hill Prince Georges . Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days M 2□F 044-36-5818 60 Director Sept. 18,1946Beckley, W. Va. Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits r 28a-f sh notified 1 Tx Yes 2 □ No Director D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2 iner must be n Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 2712 P. Street N.W. 20016 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXVes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify: Black 3 ☐ Widowed 4 ☑ Divorced 'natural", the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Car Salesman Private If Item 27 is marked other or other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk Be Mildred Turner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 2712 P. Street N.W. Washington, D.C. Guy_Green II /Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important; If any injury or once, New Pinegrove 8/27/2007 4 ☐ Donation 5 ☐ Other (Specify) Waterbury, Ct. 21. Signature of Funeral Service Acensee 22. Name and Address of Facility Alexander, S. Pope, P.A. 5538 Mariboro Pike/Forestville, Md. 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20747 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical the nse IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Honknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No cate has b autonsy performed certificate 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Mother (Specify) Friend's Residence 6 Nother (Specify) Friend's Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 9

P.O. Box 68760, Division or Vital Records,

the Hospital

State Registrar

29b. Signature and title of certifier

29a. Certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

31. Date filed (Month, Day, SEP 1 0 2007

	1-	State Regist
ı	1.	Deceden

For

Funeral Director

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed swithin 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

ian cal	Decedent's Name (First, Middle, Last)						0 T (0
	Mary Josephine	GIOVANONI			2. Date of Death Month September	9, 2007	3. Time of Death
ner	4a. Facility Name (If not institution, give street and number	r)	4b. City, Town, or	Location of Death		4c. County of Dea	th
	10804 Coffman Avenue		Hagersto	own		Washing	ton
		Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9 Bir	thplace (State or Forei
	010-22-7370	79 Yrs.	World S Days	Tiodis IVIII.	July 6,	1928 Mas	ssachusetts
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	postice				10d. Inside City Limi
_							1 Yes 2x
cto	Maryland Washington	Hagerstow					
	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?
<u>a</u>	10804 Coffman Avenue		21740			U.S.A.	
Funeral Director	11. Marital Status 12. Was Deceder Amed Force		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates		1 ☐ Yes 2 🔀 No	Specify:		Specify:	white
			dost's House Ossure	11:-0	164	Kind of Business	Soducts.
Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	ition luring most of work)	ing	. Kind of Business	vindustry
티	Elementary/Secondary (0-12) College (1-4c	r5+)	autical e			aircraft	
ပိ	17. Father's Name (First, Middle, Last)	40101	aderear (e (First, Middle, Mair		
Be	Frank W. Jackson				Mary Goe		
မ	19a. Informant's Name/Relationship (Type, Print)	10h Meille	on Address (Street	and Number or D	al Route Number, Ci		Zin Code)
15 8	Richard L. Giovanoni – hus				Hagersto	-	
	20a Method of Disposition	20b. Place of Dispo				Location - City or	
1	1 XBurial 2 Cremation 3 Removal from Sta	cemetery, crer	natory or other place	θ)	mber		
	4 ☐ Donation 5 ☐ Other (Specify)	Greenlawn	Memorial	Park 13,	2007 Wi		rt, Maryla
1	21. Signature of Funeral Service Licensee		2. Name and Addres	1.1	innich Fu		
	roll & all	41	5 East Wi	lson Blv	d., Hagers	stown, Ma	ryland 21
	23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not ent line.	er the mode of dying	g, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	Muse la	arge (el l	ymph	one	3 Onset and Death
al Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	as a consequence of): as a consequence of): as a consequence of):	lyn	el l hocyt	ymph Lleuk	me	Onset and Death
	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.		Lyn	ev l Nocyt	ymph Llouk	me	Onset and Death
an/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcomediate cause in the past 12 months?	as a consequence of): ne of pregnancy 2 □ Fetal death 3 □ at time of death 5 □	DEctopic pregnancy Other (specify)	el l hocyti	ymph Llouk	23d. Date of de Month	Onset and Death
Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	ne of pregnancy 2 Fetal death 3 at time of death 5	Other (specify)	,		23d. Date of de Month	Onset and Death Onset and Death Olivery Day Year
by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or and the cause of the cause of the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause)	ne of pregnancy 2 Fetal death 3 at time of death 5	Other (specify)	,		23d. Date of de Month	Onset and Death Plivery Day Year To the cause of death?
by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or and the cause of the cause of the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause) Due to (or and the cause)	ne of pregnancy 2 Fetal death 3 at time of death 5	Other (specify)	,	23e. Did tobac 1 Yes 24a. Was an autopsy performed	23d. Date of de Month co use contribute t 2	Onset and Death Slivery Day Year Trobably 4 Unknowutopsy findings availa completion of cause
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 09 2007 /Medical Marion W. Golden 04 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MD WMHS Frostburg Nursing & Rehab Ctr Frostburg, Allegany Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 🕱 F Months Hours Director 220-80-3505 6-4-1913 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ıral", or items 23a or 28a-f sh I Examiner must be notified 1 ☐ Yes 2 No Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13903 Winchester Rd 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 10, Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: ģ 3 X Widowed 4 ☐ Divorced White "natural" Completed the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) vitrii. Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Durr ၉ Esther Drew 19a. Informant's Name/Relationship (Type. Print) SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 715 Nemacolin Ave Cumberland MD 21502 ce of Disposition (Name of Date 20c. Location - City or Town. State Department of Health Important: If item 27 any injury or other to once. <u>Clarence E. Golden</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 ▼ Removal from State 4 □ Donation 5 □ Other (Specify) 9-8-2007 | Cumberland, MD Sunset Memorial 22. Name and Address of Facility Harvey H. Zeigler Funeral 21. Signature of Funeral Service Licens Home 169 Clarence St., Hyndman PA 15545 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** stage Dementia 6months End /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician/Medical Examiner þ Be Completed

25. Was case referred to medical examiner? Certification: To 27. Manner of Death

Medical

physician and s the burial-trans attending properties for use as Director: / within 24 hours after To the Funeral Discompletely filled in

Division or Vital Records, P.O. Box 68760,

nds State

Registrar

IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

1 Yes 2 No

1 Natural 2 Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

(Check only

29b. Signature and title of certified

wor sock

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death

4□Pregnant at time of death

Due to (or as a consequence of)

9 Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

1 Yes 2 No 3 Probably 4 Unknown

death? 1 ☐ Yes

29d. Date signed (Month, Day, Year)

23e. Did tobacco use contribute to the cause of death?

24b. Were autopsy findings available prior to completion of cause of

2 No

2-00

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital: 1 Inpatient

and manner stated.

2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? Injury

Other: 4 vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

00055325

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

24a. Was an

1∐ Yes

26. Place of Death (Check only one)

Frosthing MD 21532

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

worsorlester

5 ☐ Pending investigation

6 Could not be determined

Day, Year) 0 6 2007

30. Name and address of person who completed cause of death (item 23a) (Type, Print) SHIN

Tarn Terrace

			for State Registrar	State of	f Maryl				d Mental Hy	giene	Э	
				10		Ce	rtificate of	Death	1	Reg. No	200-	7 301.22
	Physici	an	1. Decedent's Name <i>(First, Middle,</i> Glenn	Last)	Lee		Gof	f	2. Date of Do	Da	Year	3. Tuhed by et/
	/Medic Examin		4a. Facility Name (If not institution,	give street and nur			4b. City, Town, o		Septer		3, 2007	
1	LXaIIIII	ie i	626 Baker St	0	,			umberla			Alleg	
	Funeral Director		5. Social Security Number 216–22–7362	6. Sex 1 🕅 M 2 🗆 F	7. Age (In)	yrs. last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bi Min. (Month, Di 06/22	rth av, Year) /192	9. Birti Con Mar	nplace (State or Foreign untry) 'Y Land
	and w		Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	ocation					10d. Inside City Limits
	Maryli f sho ied al	tor	,	egany			Cumberlan	d				1 ∑Yes 2 No
	h the r 28a r notif	Director	10e. Street and Number	20011			10f. Zip Code			10g. Cit	tizen of What Co	untry?
	23a c		626 Baker St	reet				21502			USA	
	er de ditems	Funeral	11. Marital Status	12. Was Dece Armed Fo	rces?	n U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? an, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	0-	14. Race - Amer Black, White	
336	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by F	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ⊠ Yes If Yes, Giv Year or Da		1951 - 1973	1 ☐ Yes 2 🎇 No	Specify:			Specify:	White
20	72 hou natura lical E	sted	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual Occup	ation	working	16b. K	(ind of Business/I	
2	/ithin in ne.	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	kind of work done DO NOT use retired	during most of d)	working	1,1		
22	iiled w Hygie ther t l nt, th		12 17. Father's Name (<i>First, Middle, L</i>	2			Clerk	18 Mother's I	Name (First, Middle		.S. Army	7
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	Porter	W .		Goff		Cora	Ann			an
ary	shou and M s mar	-	19a. Informant's Name/Relationshi	p (Type. Print)		19b. Maili	ng Address (Street	and Number o	r Rural Route Numb	er, City o	or Town, State, Z	ip Code)
	and 2 ealth a n 27 i		Emily H. Goff /	Wife				eet, Cu	umberland	, Mai	ryland	21502
Baltimore,	ges 1 It of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	State		matory or other plac	i	Date		ocation - City or	
缸	it. Pa urtmen rrtant: njury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		Cu				/04/2007			
Ba	permi Depai Impoi any Ir	1	Libert C	- Ciclon					adams ram et, Cumbe			Home, P.A.
B,			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that c	aused the d						,	Approximate Interval Between
	Physician	i	Immediate Cause (Final disease or condition	a F	HYEA	OCAR	CINOM	A OI	FLUN	G-		Onset and Death
e e	/Medical Examiner		resulting in death)			sequence of):						Julian
	7.00	Examiner	Sequentially list conditions,	b. — Due to (ur ae a runi	sequence of):						
	cuted id ansit		Sequentially list conditions, if any, each is to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
9	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a con	sequence of):						
8760,		dical	•	d								
Box 6	The law requires that the death certifitate has been signed by the attending age 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out							23d. Date of deli	Verv
W	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		irth 2 P		Ectopic pregnancy Other (specify)	·			Month	Day Year
P. O.	at the	Phys	9 Unknown						- 1			
ds,	res t igne be c	þ	Part II. Other significant condition	s contributing to de	eath but not	resulting in the u	nderlying cause giv	en in Part I.				the cause of death?
COL	w requ	Completed							24a. Was			
Division or Vital Records,	The law te has age 2 s						· · · · · · · · · · · · · · · · · · ·		auto	psy ormed?	prior to c	opsy findings available ompletion of cause of
<u>ita</u>		BeC	25. Was case referred to medical examiner?					26. Place of [1 Yes Death (Check only o	2 No one)) ILITES	2 □ No
2 V	동 두 등	은	1 ☐ Yes 2 ☑ No		<u> </u>	ER/Outpatier		4 □ Nursin	ig Home 5 ☑ Resi			ify)
on (After fune	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga		njury h, Day Year	28b. Time of Injury	Wor	yat k? Yes 2 ⊟ No	28d. Describe	how injui	ry occurred	
<u>ISi</u>	Attending Ph ar death. rector: After th by the funeral	Certification:	3 Suicide 6 Could no	t be 28e. Place	of injury - A	t home, farm, str	eet, factory, office	103 2 10				ral Route Number,
á	tal or s afte al Dira ed in B	Cert	4 Homicide determin	bullair	ng, etc. (Sp	еспу)			City or To	wn, State	9)	
	Hospi 4 hou Funer		(Check only 2 Medical E	xaminer: On the ba	asis of exam	knowledge, deat	n occurred at the tir	ne, date and pl	lace, and due to the	cause(s)) and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the complet	Medical	one) 29b. Signature and title of certifier	and mann	ner stated.	1/	29c. Licens				te signed (Month	
	F≯Fŏ) (1)		VV	V		0023371				4, 2007
7	1/1UA		30. Name and address of person w	no completed caus	e of death (I	tem 23a) (Type,					1	,
	nes		Qamar U. Zar				Avenue, C	umberla	and, Mary	land	21502	
	Sta Registra		31. Date filed (Month, Day, Year))7 2. Re	egistrar's Si	gnature	(c)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** TASKINS DIANE 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE SOUTHERN MARYLAND HOSPITAL GEORGE CLINTON 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 € F Months 216-50-9606 60 Director Washington DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 → ¥és 2 No Director MD PRINCE HILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 1005 MARCY Y SA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Yes PNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 □ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed 11th Care Giver permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Irene I. Gantt Leroy Spriggs 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1003 Marcy Ave., #104 Oxon Hill, Md. 20745 Denise Degree (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory | 09-10-07 Beltsville, Md. 22. Name and Address of Eacility
W. H. Bacon Funeral Home, Inc.
3447 14th Street, N. W. Washington, DC 20010 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARDS RESPIRATORY **Physician** ADULT /Medical Due to (or as a consequence of): Examiner IDIOPATELIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical as the ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 □ Pregnant at time of death 5 Other (specify) 9□Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 SEPSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of certificate has performe death? 1 ☐ Yes 1∐ Yes 2□ No 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2No 1 Tes 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred al or Attending Fatter death. 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated.

To the I within 2

State Registrar 31. Date filed (Month, Day, Year) SEP 0 7 2007

CHIGBUE

M. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

7943 CENTRAL

29d. Date signed (Month, Day, Year)

			1- State of Maryland / Department of Healt Registrar Certificate of Dealt	lth and M ath	ental Hygid Reg	. No. 2007	30424
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	Gentry Noffsinger Cahoon Gingell 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locat	ation of Death	Septembe	er 4, 200'	
	Examin	er	Shady Grove Adventist Hospital Rockvill			Montgom	
	Funeral		1 M 2 F Months Days Hou	ours Min.	8. Date of Birth (Month, Day, Y	rear) Co	thplace (State or Foreign ountry)
	Director		577 – 92 – 7955 50 TIS. Usual Residence of Decedent	ı	July 29,	1957 Was	hington, DC
	anylane show d at	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 Tyes 2 XNo
	the Ma	Director	Maryland Montgomery Montgomery V 10e. Street and Number 10f. Zip Code	Village	100	. Citizen of What Co	
	3a or		20002 Hoffstead Lane 20886		100	USA	ountry:
	r deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanie If Yes, specify Cuban, Me	nic Origin? (Specexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
0000	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Hydiene than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	þ	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	ecify:	,	Specify: Wh	
2	"natu edical	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	g most of workin	ng 16	b. Kind of Business	/Industry
7	withir iene. r than the Me	omp	Elementary/Secondary (0-12) College (1-4or 5+) Never Worked			None	
2	d 2 should be filed within the and Mental Hygiene. 7 is marked other than "traumatic event, the Mer	Be C	17. Father's Name (First, Middle, Last)	Mother's Name	(First, Middle, Ma	,	
<u>X</u>	ould by Ment	ם			na Noffs:		
Ma	and 2 st ealth and n 27 is n er traun		19a. Informant's Name/Relationship (Type. Print) Robert A. Gingell/Brother 19b. Mailing Address (Street and No. 1377 Wright)				
	ermit Pages 1 and 2 should be filed within 72 hours after death with the Marylan eparament of Health and Mental Hydiene. I marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1	Sent	t. 6,	c. Location - City or	
Dalimino	ermit F epar m mportar ny inui		21. Signature of Juneral Service Licensee / 22. Name and Address of E			exandria, Home Inc	
	SEES						ing, MD 20901
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc shock, or heart failure. List only one cause on each line. Immediate Cause (Final	(9)			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Hill of the following in death of the following ind			ease	minutes
	Examiner		Sequentially list conditions b. Hypercho/Esterole	emi	9	21	year 18
	ed sit	iner	if any, leading to immediate Due to (of all a consequence of):				1001
•	execut n and al-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):				years
00100	tificate be executed g physician and as the burial-transit	edical	d				
) Y	ertifica ling ph		IF FEMALE:				
ממ	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months? □ The past 12 months? □ The past 12 months? □ The past 12 months? □ The past 12 months? □ The past 12 months? □ The past 12 months?			23d. Date of de Month	livery Day Year
į	t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		1		
ביט'ר	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	Part I.		cco use contribute to	the cause of death?
5	aw rec	Completed			24a. Was an		utopsy findings available
<u> </u>	The I	E Som			autopsy performee 1∐ Yes 2 X	prior to death? ∫No 1 ☐ Yes	completion of cause of : 2 □ No
) 	sician; certific rector,	Be	examiner?		(Check only one)	V	
5	y Physer this eral di	٦. ح	27. Magner of leath 28a. Date of Injury 28b. Time of 28c. Injury at		ne 5 Residence 8d. Describe how	ce 6 ☐Other (Spe	cify)
5	ending ath. or; Afti	ation	Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 ☐ Yes	2 □ No			
	al or Attracted after de I Directed in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Stree City or Town, 3	treet and Number or Rural Route Number, n, State)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical C	29a. Certifler (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date to the basis of examination and/or investigation, in my opinion, and manner stated.	ate and place, a	and due to the cau ed at the time, date	se(s) and manner as a and place, and du	s stated. e to the cause(s)
	To the within To the comple	Med	29b. Signature and title of certifier 29c. License numb	nber	29d	. Date signed (Mont	h, Day, Year)
	10		a picole Ville MD 10064	1079	1 0	1/4/07	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicole S. Vetere, M.D. 9901 Medical Center Dr	rive, R	ockville	, MD 2085	0
	Sta Registra		31. Date filed (Monts Ep Year) 6 2007 32. Refistrar's Signature				

State of Maryland / Department of Health and Mental Hygiene? 17 30425 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Rita Virginia Grignon 2:17 PM 5 2007 Sept /Medical 4a. Facility Name (If not institution, give street and number)
Solomons Nursing Center 4b. City. Town, or Location of Death 4c. County of Death Examiner Calvert Solomons If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 ☐ F Yrs 022-01-5237 88 April 6 1919 Massachuettes Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County other than "naturel", or itema 23a or 28a-f ehow rent, the Medical Examiner must be notified at Calvert Lusby 1 Yes 2 No Maryland Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11282 Gunsnoke Court 20657 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 10 Saltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own Home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked oth eny liuly or other treumatic event 908. Edward Michael Collins Certrude Mary Donnelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11282 Gunsricke Ct. Lusby MD 20657 Leslie Ann Sari – daughter 20b. Place of Disposition (Name of cometery, crematory or other place)

Metropolitan Funeral Service 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee saus 4405 Broanes Is. Rd. Part Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COMPLICATIONS OF ALZHEIMER'S Y = ACS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Iclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) Physi 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 4No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 28 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 🔭 (o this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After s after decreal Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 🗌 Homicide within 24 hours a To the Funeral [Hospita Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Sept 6, 2007 02635 and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John M. Weigel, MD110 Hospital Rd. Suite 310 Prince Frederick MD 20678 31. Date filed (Month, Day, Year) 32. Registras Signature State 1 0 2007 Registrar

DHMH 17 Rev 1/2001

State Registrar strar's Signature

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30427 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Gearha 05-30PM stephen ptember 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University or Maryland Medical MUVE Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral 1√2** M 2□ F 140-46-5791 55 Director Feb. 29, 1952 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Montgomery Silver Spring 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12404 Downer Drive 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2X If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer Sogeti Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Gearhart, Sr. Mary Shelley 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sybil F. Gearhart -wife 12404 Downer Drive Silver Spring, Maryland 20906 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 Donation 5 Dother (Specify) Metropolitan Crematory 9/5/2007 Alexandria, Virginia 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 Donald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DISPASA Mug atustitul 3 months /Medical Due to (or as a consequence of): Examiner 0551ble Preumoconio if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed MRSA Meumonia burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed certificate Yes 2 ☐ No the Hospital or Attending Physician: director, Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 20X No 1 ☐ Yes 1 inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 🗆 No within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title

30. Name and address

20 naid 31. Date filed (Month, D

DHMH 17 Rev 1/2001

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(Type, Print)

and manner stated.

on who completed cause of death (Item 23a)

Sullivan

22

gistrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

07-07098 Joseph Gatling

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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·			- For State Clegistrar	ertificate o	f Death		Reg.		01 3042
	Physici	an/	Decedent's Name (First, Middle,Last)				2. Date of Death Month D September 1	ay Year	3. Time of Death 1826 hrs
le dica	l Exami		JOSEPH THEODORE GATLING		4b. City, Town, or	Location of Death	September 1	12, 2007 4c. County of Dea	
			4a. Facility Name (if not institution, give street and number) Civista Medical Center		La Plata	: .		Charles	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yr	rs. last birthday)	If Under 1 Yea	r If Under 24Hrs	8. Date of Birth(MM/DD/YYYY) 9. E	
	Director		577 62 8895 1XM 2 F	60 Yrs	Months Days	s Hours Min.	03/11/1	947 Fore	Country) WASH., DC
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*** **** *.	any		10a. State 10b. County 10c. C	City, Town or Loca	tion				10d. Inside City Limits
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	Maryl 28a-1 d at o	Director	10e. Street and Number		10f. Zip Code			Citizen of What Co	
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_	death with the Maryland or items 23a or 28a-f sho must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X Married Armed Forces?		as Decedent of His Yes, specify Cubar			White, etc.	erican Indian, Black,
	er dez , or i r mus		1 X Yes 2 N Widowed 4 Divorced of Ses Give Year 1965-	66 1	Yes 2 X No	specify:		Specify: B	LACK
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215-0036	filed with Hygien d other , the Me		17. Father's Name (First, Middle, Last)				e (First, Middle, Ma	iden Surname)	
212	ould be fi Mental I marked ic event,	To:Be	ARPHELIUS GATLING, SR. 19a, Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Stree	INEZ LA		er, City or Town, Sta	ate, Zip Code)
MD	2 shour and 1.27 is martic	F	GLORIA GATLING / WIFE	A .					L, MD 20622
	an alt		20a. Method of Disposition 2		sition (Name of ce		Date	20c. Location - City	or Town, State
JO.	Pages I ent of I int: If		1 X Burial 2 Cremation 3 Removal from State	,	(EMORIAL	PARK 09/	20/2007	LANDOVE	R. MD
Baltimore,	permit. Page Department Important: injury or ot		4 Donation 5 Other Specify: If 21 Signature of Funeral Service Licensee					MARYLAND	
ä	permit. Depart Impor		J-P. Monshill	143	308 SUTTI	JAND ROAL	SUITL	AND, MD 2	.0/46
	ysician		23a Part I. Enter the disease, or complications that caused the de					t, shock, or heart	Approximate Interval Between Onset and
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			or condition resulting in death) Due to (or as a consequent	ce of):		,			
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760,	cate be er physiciar the burial	Mec	IF FEMALE: 23c. If yes, outcome of	pregnancy				23d. Date of deliv	
687		sician/	23b. Was decedent pregnant in the past 12 months?	of death		Ectopic pregn	ancy	Month	Day Year
Box 68	leath e atte	ysic	1 Yes 2 No 9 Unknown 9 Unknown	5 (Other (Specify)				
0.	at the d by the tached	, Phy	Part II. Other significant conditions contributing to death but i	not resulting in the	underlying cause	given in Part I.			to the cause of death?
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rds	v requir s been s should	Completed					24a. Was ar autopsy	y prior	autopsy findings available to completion of cause of
ဝ၁	he law ite has	l mc					perform 1 ✓ Yes 2		
<u>~</u>	ysician: The his certificate director, page	Be C	25. Was case referred to medical		26.Plac	e of Death (Check	only one)		
Z. Zīt	hysici this o	To B	Tes 2 No	2 ER/Outpatie					ther:
Division of Vital Records, P.O.	Jing Ph After t funeral		27. Manner of Death 1 X Natural 5 Pending	28b. Time of	· · · _ ·	ury at Work? Yes 2 No	28d. Describe ho	ow injury occurred	
sior	l or Attend after death Director: d in by the	ă;	A Natural 5 Pending Investigation 28e. Place of Injury -	At home form of			29f Location (St	reet and Number or	Rural Route Number, City
iž	after / Bafter Dire	ertification:	Suicide Could not be determined (Specify)	At nome, raim, su	eet, ractory, office	building, etc.	or Town, Sta		rear reaction removes, only
ليا	lospital Hours a Hours	10	4 Homicide 29a. Certifier A Contifuing Physician: To the best of my known	wledge death occ	surred at the time.	late and place, an	d due to the cause	(s) and manner as s	stated.
	To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ledical	one) 2 Medical Examiner: On the basis of examinati	ion and/or investig	ation, in my opinio	n, death occurred	at the time, date a	nd place, and due to	the cause(s)
	To To	Mec	29b. Signature and title of certifier		29c. Licen	se number		29d. Date signed (Month, Day, Year)
			Allen Brasel (M)		0.0	.M.E.		September 13	, 2007
0			30. Name and address of person who completed cause of death						
r			Melissa Brassell, MD Assistant Medical Exa		Penn Street,	Baltimore, MD	21201		
		tate		gnature					
	Regis	ili li	SFP 1 8 2001 France O.	100					

Please '	Type or	Print i	n Black	Indeiible Ink.	Ensure All	Copies Are	e Legible
			—				_

-elipe Gonzales-		1- For State Registrar Certificate of D		Reg	_{3.No.} 2007 3042
Physicia Medical Examir		1. Decedent's Name (First, Middle,Last) Felipe Ventura Gonzalez		2. Date of Death Month September	
pe the		4a. Facility Name (if not institution, give street and number) 4b.	. City, Town, or Location of Death		4c. County of Death
Funeral			Cheverly If Under 1 Year If Under 24Hrs.	In Date of Birth	Prince George's (MM/DD/YYYY) 9. Birthplace (State or
Director			Months Days Hours Min	1	9. Birthplace (State or Foreign Country) Mexico
. <u>*</u>		Usual Residence of Decedent		· Lacy	
nd how any ce.		10a. State 10b. County 10c. City, Town or Location Mp Prince Georges Lanham	1		10d. Inside City Limits 1 XYes 2 No
larylan 28a-f sl	Director	10e. Street and Number	10f. Zip Code .	. 100	g. Citizen of What Country?
h the N.		1202 Powhatan St	20706		Mexico
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Lant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral		Decedent of Hispanic Origin? (Sp. s, specify Cuban, Mexican, Puerto I		14. Race - American Indian, Black, White, etc.
after de		1 Yes 2 No No No No No No No No No No No No No	res 2 No specify: MeX	kican	Specify: White
hours a natura Exami	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's during most	s Usual Occupation (Give kind of w	work done	16b. Kind of Business/Industry
D 21215-0036 should be filed within 72 hour and Mental Hygiene. 7 is marked other than "mate natic event, the Medical Exan	Completed		ackager		Ice Company
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)	18.Mother's Name		aiden Surname)
121! d be fil fental I narked event,	Be	Isaias Ventura Hernandez	and the second s	Gonzalez	
ID 2 2 shoulh 3 and M 27 is m matic	우		Address (Street and Number or R 55th Pl. #103		per, City or Town, State, Zip Code)
Baltimore, MD 2 permit. Pages i and 2 shoul Department of Health and N Important: If item 27 is m injury or other traumatic.	1	20a. Method of Disposition 20b. Place of Disposition	on (Name of cemetery,		20c. Location - City or Town, State
MOF Pages nent of ant: II		1 X Burial 2 Cremation 3 Removal from State crematory or other 4 Donation 5 Other Specify: Cementerio	Principal 9	1/22/07	Tehuitzingo, Puebla
3alti ermit. Jepartin Import		21. Sign to f Funeral Service Licensee 22. Nam	me and Address of Facility	nidon /IIal	a Francisca I Home
Physician	-	23a Part I. Enter the disease, or complications that caused the death. Do not enter the r	OT3 Annapotis R	ka. Lanna	am, Md 20707
/Medical	+	failure. List only one cause on each line. Immediate Cause (Final disease a. Acute alcohol intoxication	يه د د من چار دي	:	Between Onset and Death
xaminer		or condition resulting in death) Due to (or as a consequence of):		. **	
an 1	Ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	10.00	>	
	틭	causs. Enter Uncertying Cause (Disease or injury that initiated	701250		
cuted and transit		events resulting in death) Last Due to (or as a consequence of): d			
68760, certificate be executed nding physician and as a the burial - transi	Medical	X UNPENDED X AMENDED #1.23a.27.28a-f. perME.g8	871 9 <i>/2</i> 6/07 TT		
8760 ifficate ing phy: as the t		23b. Was decedent pregnant in the			23d. Date of delivery Month Day Year
Box 68760, te death certificate be executed the attending physician and effor use as the burial - transiti	Physician/	past 12 months?	r (Specify)	ncy	MOITII Day 164
P.O. Eres that the designed by the		Part II. Other significant conditions contributing to death but not resulting in the under	derlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
S, P. uires th	ed by				2 No 3 Probably 4 ✔ Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by the funeral director, page 2 should be detach.	Completed			24a. Was an autopsy	y prior to completion of cause of
tal Rec				perform 1 Y Yes 2	
Vital Fysician: 'ysician: '	Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No. Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3	26.Place of Death (Check o		desidence 6 Other:
of V ing Phy	의	27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of Injury		·	ow injury occurred
tendii death. ctor: /	Certification:	Pending Investigation Fnd 9/15/2007 Fnd 2:10 a		unk	
Jivis al or A s after d Dire	III)	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, fa			reet and Number or Rural Route Number, City ate) /202 Powhatttan St.
ospi hou y fil		29a. Certifier		New Carro	11ton. MD
To the H. Volume 24 completel		(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.			
- F * F °	₩ T	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		ratricis aronica- Bellation	O.C.M.E.		September 17, 2007
1 (1)	1	Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner	11 Penn Street, Baltimore	MD 21201	
370	W.C	31. Date filed (Month, Day Year) 1 32. Registrar's Signature	-	5, IVID 2	, -

OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Hadle /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number **Examiner** Besthesda MD

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Hours | Min. | (Month, Day, Year) Mortsone 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 🔼 F Yrs. 217-30-2314 93 1914 Ohio July Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 No Director Montgomery Rockville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13527 Grenoble Drive 20853 USA Funeral Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 ∐ Yes 2**√∑M**No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White ð 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Harry R. Marker Nelle Campbell Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13527 Grenoble Drive, Rockville, MD 20853 Natalie Hadley Craven/Daughter item 2 20b. Place of Disposition (Name of cemetery crematory or other place)
Gate of Heaven Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Sept Pate Department of H Important: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee J. Keir Skiles 500 University Blvd, W, Silver Spring. MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Imua-du Physician Hasma toma disease or condition resulting in death) 1/1/2 /Medical Due to (or as a consequence of): OVED BY MEDICAL EXAMINER Examiner Sequentially list conditions. Directo (or as a nunsecuence of) If any, leaving to himself cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine CERTIFICATE attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No performed yes 2 No autopsy adley, Gladys 25. Was case referred to medical examinar? Be 26. Place of Death (Check only one) Hospital: 1 es Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 R/Outpatient 3 DOA P 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☑ No 6 9 2 Accident 6 ☐ Could not be 28e. Price of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number City or Town, State) determined 4 ☐ Homicide Rockule, glate, Home To the Hospital within 24 hours a To the Funeral C 1 ** **ertifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ** **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature a of title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) gotown s of person hn'stopher Burns

State Registrar 31. Date filed (Month, Day, Year SEP 1 0 2007

32. Registrar's Signatu

		•	For State Registrar	State of Maryland	-	artment of H tificate of L			2007	30432
	- · · ·		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Takia Wynette Hid	cks				Septemb	er 6, 2007	10:45 A.M
ş	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of Death	
			N.M.S. Healthcare	of Hagerstown	l		erstown		Washington	1
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la M 2 F 28	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		lace (Stete or Foreign try)
	Director		578-04-6784 Usual Residence of Decedent	X 20	113.			9/23/78	Cheve	erly,Md.
	land ow		10a. State 10b. County	10c. City,	Town or Lo	cation			1	0d. Inside City Limits
	Mary -fsh fied	ţō	Md. Prince Geo	orge's Se	at Ple	easant				X □Yes 2□No
	r 28e	Director	10e. Street and Number			10f. Zip Code		109	g. Citizen of What Coun	try?
	should be filed within 72 hours after death with the Maryland tod Mental Hygiene. marked other then "naturel", or iteme 23e or 28e-f show marked other then "naturel", or iteme 23e or 28e-f show metic event, If a Medical Examiner must be notified at	a D	6310 Carrington (Court			20743		U.S.A.	
	deat	Funeral	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	i. 13. \	Was Decedent of Hi	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
စ္	or ite	F	1 Never Married 2 ☐ Married	1 ☐ Yes 2X No If Yes, Give		I ☐ Yes 2√☐ No	Specify:			rican-
2-0036	urel',	d by	3 Widowed 4 Divorced	Year or Dates:					Ame	erican
	nati	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	ient's Usual Occupa kind of work done o	ation furing most of workii)	ng 1	6b. Kind of Business/Ind	lustry
2	withir ane.	m d	Elementary/Secondary (0-12)	College (1-4or 5+)			/		Dankara	_4_
Maryland 2121	filed Hygie Hygie other ant, II	ပ္ပ	12th 17. Father's Name (First, Middle, Last)		ма	nager	18. Mother's Name	(First, Middle, Ma	Restaurar aiden Sumame)	IC.
an	0 = 0 >	o Be	George L. Hicks	z .Tr			D	Manage 1	_	
₹	shoul of Me mark meti	ဥ	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street a		. Trembl	City or Town, State, Zip	Code)
	Ith ar 27 is r treu		Karen D. Murray/M	other	124	East 15th	Avenue, H	omestead	l, Pa. 1512)
ē,	s 1 ar f Hea item other		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of natory or other place	e) D	ate 20	0c. Location - City or To	wn, State
Ê	Page: ent o nt: If ry or		1 ØBurial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	anioval nom State		Mem. Park	٠	07 т	andover, Ma	arvland
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Importent: If item 27 is marked eny injury or other treumetic e one.		21. Signature of Funeral Service License			Name and Address	s of Facility			1
ñ	Depared Important Permi	2. 4	1) any	W. 5164	4	H.S.Wash 925 Burro	ington &	Sons Co.	,inc. shington,D	C-20019
			23a. Part1. Enter the disease or compli- shock, or heart failure. List only on	cations that caused the death.						Approximate Interval Between
	Physician	8 7	Immediate Cause (Final disease or condition	Acquir	. 1	F.mm.	anadel	, wenn	4	Onset and Death
П	/Medical		resulting in death)	Due to (or as a conseque		7 44.	nnedef	5. md	v. we	
	Examiner	Examiner	Sequentially list conditions,					79.00		
	p #		if any, leading to immediate	Due to (or as a conseque	ence of):					
	acute and trans	am	Cause (Disease or injury that initiated events resulting in death) Last							
50,	oe ex		rosaning in doutin, East	Due to (or as a conseque	ence of):					
68760	ilicate be executed g physician and as the burial-transit	edical								
_	= D 6	/Me	IF FEMALE:	3c. If yes, outcome of pregnan	icv				22d Date of delive	
Вох	eath certif attending for use a	lan	in the past 12 months?	1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	Day Year
o.	the de	Physiclan/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown	uiii 0 _	Totale (Specify)				
Д.	The law requires that the death cert to the has been signed by the attendinage 2 should be detached for use	F.	Part II. Other significant conditions con	tributing to death but not resul	ting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to th	e cause of death?
Vital Records,	uires sigr kd be	d by						1 ☐ Yes	s 2 □ No 3 □ Prob	ably 4 Dunknown
ဂ ္ဂ	w req	lete						24a. Was an	24b. Were auto	psy findings available
Re	he lav e has	Completed						autopsy	ed? death?	psy findings available appletion of cause of
g			25. Was case referred to medical				26. Place of Death		No 1 Yes	2LJ N0
	Physicien: The la r this certificate has ral director, page 2	To Be	examiner?	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 DOA Othe			nce 6 Other (Specify	()
Division of	g Phy er this eral c		27. Manner of Death		28b. Time of		at	28d. Describe how		,
0	nding th. r: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(WOTHI, Day 1841)	Injury		Yes 2 □ No			
N S	or Attending after death. Director: After in by the funer	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,
	s after s Dire ed in b	Certification;	T I HOMBIGO	building, etc. (opcony)						
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Examir	sician: To the best of my knowner: On the basis of examination						
	To the within 2. To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	29	d. Date signed (Month,	Dey, Year)
)	N IN IN		1 du m	uly			16039	(09/06	107
			30. Name and address of person who co	mpleted cause of death (Item)	22a) (Tupe			20.1	ch	1 /
						ennn				
_			FAM n	my ns Ho	ZSa) (Type,	M.).	1126	1000	~~~	11740
	Sta	te	31. Date illed Month, Day Yaar	32. Registrar's Signatu	23a) (Type,	м.у.	Hogers	forn	, mo	21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State engistrar WCHD/SH 9/14/07 per FH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Jeanette Virginia Hodges September 9,2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Ravenwood Lutheran Village Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🖼 F 215-76-2343 8/12/1919 West Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1√Yes 2 No Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1012 Rosehill Ave 21740 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Franklin Thompson Pauline Flora Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph H. Hodges/husband 1012 Rosehill Ave. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 9/13/2007 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Cemetery 9/15/2007 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 5. Mark 1601 Pennsylvania Ave. Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atteroschofie Cardiovosculou desease MINS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IE FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24a. Was an autopsy Were autopsy findings available prior to completion of cause of performed death? 1 ☐ Yes 1∐ Yes 2.00 No 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner The law requires that the death certificate be executed and the burial-trar Division or Vital Records, P.O. Box 68760. physician as

Examiner

Physician/Medical

Completed by

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Certification:

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Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Exa<u>miner must be notified at</u>

other than "natu vent, the Medical

or other

permit. Page Department of Important: If any Injury or

filed within 72 hours after death with

2 should be fi and Mental F 27 Is marked or traumatic even s 1 and 2 should b Health and Ment tem 27 Is marked

Maryland 21215-0036

Baltimore, Pages 1 ; ment of Hr Director

Funeral

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Completed

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signed by peen has certificate this completely filled in by the funeral after death. Director: After

Attending Physician:

Hospital or To the Hospital within 24 hours at To the Funeral C

05H-0

25. Was case referred to medical examiner?

27. Manner of Death

29a, Certifier (Check only

3 Suicide 4 ☐ Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number D 25365

Sheet Ha gedoin MD

29d. Date signed (Month, Day, Year) 9-10-07

30. Name and address of person who completed cause of beath (Item 23a) (Type, Print) AW 368 nucl DF4.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 8 SEPTEMBER 2007 10:13 PM MARY LOUISE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WASHINGTON HOMEWOOD RETIREMENT CENTER WILLIAMSPORT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Hours Months Days 1 □ M 2 1 1 F 79 212-24-6080 Director APRIL 7, 1928 PENNSYLVANIA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits t be notified at 10a, State 10b. County 1 TYes 2 X No Director MARYLAND WASHINGTON WILLIAMSPORT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21795 U.S.A. 16505 VIRGINIA AVENUE items 23a other traumatic event, the Medical Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2X If Yes, Give Year or Dates: 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ₩ Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY HINKLE YEAKLEY JOSEPH LUTHER BECKLEY 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trac 17306 BRANDEN TERRACE, HAGERSTOWN, MARYLAND 21740 G. SHERMAN HORN/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 Removal from State 5 Other (Specify) 19/13/2007 4 □ Donati ROSE HILL CEMETERY HAGERSTOWN, MARYLAND 22. Name and Address of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final nonko Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): attending physician Division or Vital Records, P.O. Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2/No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of death? autopsy perform 2 🗆 No 1 □Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 💥 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA P Wall Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this hin 24 hours after death.

the Funeral Director: After thi

mpletely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural
Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier rammer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and titl pleted cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death _ Month r 5, 2007 **Physician** September Sallie Ann Hedenstad /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Severna Park Anne Arundel 325 Hollyberry Road If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1□M 2**X**X Feb. 1932 California Director 551-38-3027 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√1No Funeral Directo Maryland | Severna Park Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21146 325 Hollyberry Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 277No If Yes, Give Year or Dates: 14. Race - Americen Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2√TVNo Specify: White Be Completed by 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Elder Services Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Juanita Collier Dr. Leslie J. Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Severna Park, Maryland 21146 Charles R. Hedenstad / Husband 325 Hollyberry Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X☐Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 9/6/2007 Baltimore Crematory 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service License 1 lichel 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Examiner-Completed by Physician/Medical Examiner Be P Certification:

To the Hospital or Attending Physician: The law requires that the death certificate be executed ing physician and e as the burial-trans Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Baltimore, Maryland 21215-0036

	Immediate Cause (Final disease or condition resulting in death)	a. Bras Canc	er		4 years
_	Sequentially list conditions,	b			
I Examine	if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	c			
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 N No	4☐Pregnant at time of death 5☐ Othe	ic pregnancy r (specify)		ate of delivery onth Day Year
by Phys	9 Unknow	9□Unknown contributing to death but not resulting in the underlyi	ng cause given in Part I.	23e. Did tobacco use con 1 ☐ Yes 2 No	tribute to the cause of death?
ompleted				24a. Was an autopsy performed2	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
	25. Was case referred to medical		26. Place of Death (C)		
To Be	examiner? 1 ☐ Yes 22 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	Other	5 Residence 6 □Ott	ner (Specify)
ation: 1	27. Manner of Death Natural 5 Pending 2 Accident investigation	I F	28c. Injury at Work? 1 Yes 2 No	Describe how injury occur	rred
Medical Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ctory, office 28f.	Location (Street and Numi City or Town, State)	ber or Rural Route Number,
dical (29a. Certifier 1 Certifying Pt (Check only one)	hysician: To the best of my knowledge, death occu miner: On the basis of examination and/or investige and manner stated.	rred at the time, date and place, and ation, in my opinion, death occurred a	due to the cause(s) and mat the time, date and place	nanner as stated. , and due to the cause(s)
Me	29b. Signature and title of certifier		29c. License number	29d. Date signe	ed (Month, Day, Year)

September 5, 2007

State Registrar

31. Date filed (Month, Day, Year) SEP 0 6 2007

30. Name an inddress of person who completed ceuse of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30436 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Hite Audrey 18:00 P M September 1, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany WMHS-Memorial Campus Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/27/1939 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F Months Days Hours 68 215-36-9435 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Allegany Mt. Savage 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21545 USA 12623 Breezewood Lane, NW 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ▼ No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner and Operator Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norman Russell Merrill Elsie Bell Wilt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary A. Hite, Sr. / Husband 12623 Breezewood Lane, NW., Mt. Savage, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Mem. Gardens 09/05/2007 LaVale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Anaphylactic Shock Due to (or as a consequence of): Beesting Due to (or as a consequence of): Due to (or as a consequence of): GOT 4 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2X No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X ER/Outpatient 3 □ DOA Date of Injury (Μοπth, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury

Physician /Medical **Examiner** the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

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Pages 1 and 2 should be facent of Health and Mental Is marked

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permit. Pages Department of Important: If it any injury or o once.

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Baltimore, Maryland 21215-0036

Records, P.O. Box 68760,

Division or Vital

Examine Physician/Medical 9 Completed Be ည

burial-transit and signed by the aftending physician to be detached for use as the buria peen has To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral. Certification:

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> State Registrar

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🔀 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hyperlipidemia Coronary Artery Disease 25. Was case referred to medical examiner?

12 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☑ No unk. P M 2 Accident 09/01/2007 Beesting 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 2023Breezewood Lane 4 ☐ Homicide At home Mt. Savage, Maryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

MI. D46346

29c. License number 29d. Date signed (Month, Day, Year)

September 4, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

well

625 Kent Avenue, Cumberland, Maryland Huma Shakil, M.D.,

31. Date filed (M

29b. Signature and title of certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5&7 Per I'H 6871 9/24/Department of Health and Mental Hygiene
Certificate of Death
Reg, No. For A State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 29 04 1:45 PM 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico tospice If Under 24 H at the Calle Birthplace (State or Foreign Country) **228**-20-0932 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday **Funeral** Months Davs Hours 1 M 2 □ F 75 Director MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland December of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any rijury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 8 UNIted STAT Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Worcester Cu. Ride DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) IAYLOR 07 HARMON ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARMON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 ☐ Cremation 3 Removal from State 9/08/2007 Cool Springs Cemetery Girdlettee, Md any mjury c 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Bennie Smith 21. Signal III of File ral Scrylo, Licensee FUNETAL Bennie W. ISAbella St. SALISBURY, md 21801 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burla Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No the detached 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ be 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 2 No 24a. Was an certificate has autopsy Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) No No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 🗌 Yes 2 ER/Outpatient 3□ DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Maryner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury Hospital or Attending 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident death hin 24 hours after death the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

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State

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 State
Registra AMEND#28, penMD, 9/7/07, DPS, MbCb Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** John Martin Heneghan September 3. 2007 8:36 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner 7400 Lakeview Drive, #109 Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1**√2**M 2□ F Director 79 054-20-9298 22, 1927 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location ia or 28a-f show t be notified at 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a cliner must by 7400 Lakeview Drive, #109 20817 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ <u>Administrator</u> Federal Government is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Heneghan Delia Mongan 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7400 Lakeview Drive, #109, Bethesda, MD 20817 item 27 i Mary Coyle Heneghan/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If its any Injury or o Sept. ₩ Burial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) Silver Spring, Maryland 2007 21. Signature of Muneral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part1. Enter the disease, or comp shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPI 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an Was a... autopsy performed? Yes 2 No certificate has b irector, page 2 sl 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: 4 Nursing Home 1 ☐ Yes ို 21 JER/Outpatient 3□ DOA 5 Residence 6 □Other (Specify) this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Iniury 1 ☐ Yes 2 ☐ No n 24 hours after death.

Ne Funeral Director; A sletely filled in by the fu 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2. 29b. Signatur 29d. Date signed (Month, Day, Year) 20+1 JOH address of person who completed cause of death (Item 23a) (Type, Print) 30. Name 31. Date filed (Month, State

DHMH 17 Rev 1/2001

Registrar

07-06867

Pauline Lucille Higdon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 30439

		I- For State		Certific	ate of	Death				F	Reg. No.			
Physici	Registrar 1. Decedent's Name (First, Middle,Last) 2. Decedent's Name (First, Middle,Last)										ath Day Yea	or	3. Time of Death	
ledical Exam	iner	Pauline Luci	lle Higdon							Septemb	Day Yea er 4, 2007	aı	1020 hrs	
A 10 10		4a. Facility Name (if not institut	0	umber)	41	b. City, Tov	vn, or Lo	ocation of			4c. County	of Deat	h	
		11711 Galt Avenue	, 3			Silver S	Spring			3	Montgo	mery		
			6. Sex	7. Age (In yrs. last bir	thday)	If Under	1 Year	If Under	24Hrs.	8. Date of B	irth(MM/DD/YYYY	Y) 9. Bi	rthplace (State or	
Funeral		5. Social Security Number	6. Sex	1. Age (III yis. last bii	alouy,	Months		Hours	Min.			Forei	ign	
Director		189-34-5050	1 M 2 X F	63	Yrs.					04/1	3/1944	Pen	nisylvania	
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any	1	10a. State 10b. County	y 10c. City, Town or Location										10d. Inside City Limits	
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with mrs 2	Funeral	11. Marital Status	A area or al	ecedent Ever in U.S. Forces?		s Decedent es, specify				cify Yes or Nican, etc.)		te, etc.	rican indian, black,	
death r ite	Š	1 Never Married 2 X	Married 1 Yes	2 x No									*** ·	
fler of I'', o	빗	3 Widowed 4 D	Divorced If Yes, Give Your Dates:	ear	1	Yes 2 3	No	specify:			Specify:		White	
urs a fura	d by	15. Decedent's Education (Sp		ade completed) 16a.		's Usual O					16b. Kind of B	Business	/Industry	
2 ho	eted	Elementary/Secondary (0-12	2) College	(1-4 or 5+)	during mo	ost of worki	ng lire. i	DO NOT	se reme	u)	1 4 4			
36 uin 7 Ilhan dica	Comple		2			Waitre	ess			36	Resta	auran	nt	
witi	6	17. Father's Name (First, Midd						8. Mother's	Name (F	First, Middle	, Maiden Surnam	ie)		
15 Filed Hy t, th	O	,						1.	Margai	ret.	Unobtaina	able		
21215-0036 Montal Hygiene. Mental Hygiene in an marked other than the event, the Medica	o Be	Edward Eiche 19a Informant's Name/Relatio		11	9h Mailing	Address	/Street		-		umber, City or To		te, Zip:Code)	
houl houl is m	F								, ,					
MD and 2 sho alth and m 27 is		John K. Higd	on - Spouse	. 20b. Place						n, Mary Date	1and 20902		or Town, State	
Hear Fiter	١, ١	20a. Method of Disposition 1 X Burial 2 Cremati	ion 2 Romaval		atory or oth		e or cem	etery,		Date	200. Eddallon	Oity	y rouni, oldto	
ages nt of othe	9			Park1a	wn Mem	orial	Park	- 1	9/12	2/2007	Rockvi	111e,	Maryland	
ltin it. P		4 Donation 5 Other 21. Signature of Funeral Servi	ce Licensee	1 4	22. N	lame and A	ddress	of Facility						
Baltimore, MD 21215-0036 permit. Pages 1-and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	1	Ola		all .						Home, I		ina	Maryland 20904	
		23a. Part I, Enter the disease		caused the death. Do i	not enter th	ne mode of	dving. s	such as ca	ardiac or i	respiratory a	arrest, shock, or h	neart	Approximate Interval	
Physiciar /Medica		failure, List only one cau	se on each line.							171			Between Onset and Death	
kamine	_	Immediate Cause (Final disea		sive Atherosclerot	ic Cardi	ovascul	ar Dise	ease			14.	-	200	
		or condition resulting in death) Due to (or as	s a consequence of):										
		Sequentially list conditions,	b. <u>·</u>									_	<u> </u>	
	Examiner	if any, leading to immediate cause. Enter Underlying Cau		s a consequence of):				7.1					7	
	Ē	(Disease or injury that initiated	d C.	s a consequence of):	_			_	_					
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760, cate be executed physician and			0											
O, e be ex ysician burial	n/Medical	UNPENDED	AMENDE	J										
8760, ifficate b ng physic	Į	IF FEMALE: 23b. Was decedent pregnant in	a Abra	s, outcome of pregnand			ء ٦				23d. Date Month		rery Day Year	
5.0. Box 687 that the death certiff need by the attending need by the attending detached for use as a	an	past 12 months?	,	e birth egnant at time of death	2 Fe		3 [Ectopic	pregnan	icy	Worth		Day 1 can	
Box 68 e death certi the attendin	Sic	1 Yes 2 No 9 🗸	Unknown		5 Ot	ther (Spec	rry)							
e de G	Physicia		9011	known	inn in the .			ivon in Da	et l	23e Di	d tobacco use cor	ntribute	to the cause of death?	
P.O.	by F	Part II. Other significant con	iditions contributing	g to death but not result	ing in the t	undenying	cause y	iven in re	11.				Probably 4 V Unknown	
, P.C fres that signed														
ords, w requir	Completed									24a. W	as an 24t topsy		autopsy findings available to completion of cause of	
SOF law 1 has t	ᅙ									pe	rformed?	death	?	
Zecate	Ę										s 2 No	1 🗸	Yes 2 No	
tal Rec	e e	25. Was case referred to med				2		of Death	(Check o	nly one)		_		
Vita ysici his co		examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 ER	/Outpatien	t 3 D	OA	Other ₄	Nursing	Home 5	Residence 6	ot 🗸 Ot	her: Scene	
ing Ph After t	<u>ا</u>	27. Manner of Death	28a. Da	ate of Injury 28i onth, Day,Year)	b. Time of	Injury 2	8c. Injur	ry at Work	(?	28d. Descri	be how injury occ	urred		
indin	<u>.</u>	1 V Natural 5 P	ending	ontri, Day, rear)			1 \	res 2	No					
Vision or Attend after death Director:	g 5		nvestigation 28e P	lace of Injury - At home	farm, stre	et, factory.	office b	uilding, el	tc.	28f. Locatio	n (Street and Nur	mber or	Rural Route Number, City	
Division of Vital Records, tal or Attending Physician: The law requirers after death. By Directors: After this certificate has been is law in by the finered mane?	[[could not be etermined (Spec							or Tow	n, State)			
spita 10urs	၂ ပ	4 Homicide	100						- 4				totad	
e Ho		29a. Certifier 1 Certifying	g Physician: To the	best of my knowledge, o	death occu	irred at the	time, da	ate and pla	ace, and	due to the c	ause(s) and man ate and place, an	ner as s id due to	o the cause(s)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and manual birector. After this certificate by specially of the fameral director nace 2 should be detached for use as the burial-transit.	edical	Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.								. are arre, d				
F 3 F 8	∑ 295 Signature and title of certifier 235. Elegate number 235.											(Month, Day, Year)		
12	1	1+4. ().	000	- Valla	7.,		O.C.	M.E.			Septemb	per 5,	2007	
100		30. Name and address of per	WYLL-	rause of death /Item 23:	2)		.		_	_				
		30. Name and address of per Patricia Aronica-Po		istant Medical Exa		111 P	enn St	treet. Ba	altimore	e, MD 21	201			
			1 30	Distraria Signatura		A								
	State istra	the state of the s	^{2ar)} 7 2007 32	. Registrar's Signature	1	Sept.								
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DHMH 17 Rev 1/2001

Holler

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,		r lease 1	State of Mary				nd Mental Hy	giene	00111
		1 - For State Registrar	. Ta	Ce	rtificate of	f Death		Reg. N2007	30441
Physic	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Year	
/Medi	cal	John E. Hocker, 4a. Facility Name (If not institution, give s			4b. City, Town,	or Location of		er 5, 2007	13:09 MPN
Examir	ner	Union Hospital of		37	E1kt		Oballi	Cecil	
Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday		r If Under 2	24 Hrs. 8. Date of Bir Min. (Month, Da	th 9. Bi	rthplace (State or Foreign
Director		192-22-8058	M 2□F 77	Yrs.	I WOTTERS Out	3 710013	Oct. 8,		nnsylvania
and		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or I	ocation				10d. Inside City Limits
Maryl	ţ	Maryland Cecil		E1kto	n				1 ☐ Yes 2 📉 No
death with the Maryland me 23a or 28e-f ehow Linual be notified at	Director	10e. Street and Number			10f. Zip Code)		10g. Citizen of What 0	Country?
ath will		807 Old Elk Neck			2192			United Sta	
iteme	Funeral	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever Armed Forces?	in U.S. 13	. Was Decedent of If Yes, specify Cu	f Hispanic Orig uban, Mexican,	in? (Specify Yes or No , Puerto Rican, etc.)	14. Race - An Black, Wh	
OU36 hours after turel; or ite	Ď	3 □ Widowed 4 1 Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: US	Navy	1 ☐ Yes 2 🛱 N	lo Specify:		Specify:	White
Z1Z15-0036 bd within 72 hours after death with the Marylan giene. et than "netural", or iteme 23s or 28e-f ehow it he Medical Examinar nivet by motified at	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Dec	edent's Usual Occ e kind of work don	ne during most	of working	16b. Kind of Busines	s/Industry
within 72 ene.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use reti	·			
be filed v tal Hygie d other		12 17. Father's Name (First, Middle, Last)		Trav	el Agenc		r's Name (First, Middle	Travel , Maiden Sumame)	
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	To Be	John E. Hocker, S	r.			Elsi	ie (Unkr	nown) — —	
re, Maryland s 1 and 2 should be file f Health and Mental Hy ltem 27 le marked oth other treumatic event		19a. Informant's Name/Relationship (Typ	•					er, City or Town, State	
- 650 -		Richard S. Hocker					oad, Elktor	Maryland 20c. Location - City	
0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emovar from State		oosition (Name of ematory or other p	1 -	September		
Baltimo permit. Page Depertment Important: I eny injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Survice ☐ ense			e Cremat 22. Name and Ado		7, 2007 Crouch Fur	Newark, De	laware
Depo Personal		Vallet S							ary1and 21901
		23a Part1. Enter the disease, or complik shock, or heart failure. List only on	cations that caused the e cause on each line.						Approximate Interval Between
Pnysician		Immediate Cause (Finat disease or condition		nt Sus	IAMOUS (Cell C4!	DESE OF	tinbul	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a co	nsequence ar):			o materials		
4	<u>~</u>	Sequentially list conditions, if any teading to immediate	Due to (or as a co		uthitis				
uted d ansit	Examiner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
60, be executed icien and burial-transit		resulting in death) Last	Due to (or as a co	nsequence of):					
S S B	licai								
= 00 00	Completed by Physician/Med	IF FEMALE:	3c. tf yes, outcome of pr	egnancy				23d. Date of d	leliver/
BOX death cert attendin	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ 4 Pregnant at time	Fetal death 3	☐Ectopic pregnal			Month	Day Year
trithe d	hysi	9 Unknown	9□Unknown						
45, P.O. I	by P	Part It. Other significant conditions con	1	t resulting in the	underlying cause	given in Part I.		tobacco use contribute	
COrdi	ted	Hyper Tension	/				1	/- \ _	Probably 4 Unknown
e law	npie	Aypothymid					24a. Was		autopsy findings available o completion of cause of ?
al F		OF Man area referred to medical				00.51	1 ☐ Yes	2 No 1 Y	es 2 No
Division of Vital Records, or Attending Physician: The law requires t after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	o Be	25. Was case referred to medical examiner?	ospital:	2 ER/Outpati	ent 3 DOA	Other	of Death (Check only	one) idence 6 □Other(Si	pecify)
ig Phy terthii	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time	of 28c. In			how injury occurred	
SiOr endin eath. or: Af	catic	2 Accident investigation			M 1	☐Yes 2☐			
or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of tnjury - building, etc. (S	At home, farm, : pecify)	street, factory, office	сө		(Street and Number or wn, State)	Rural Route Number,
Division of Vital Wither Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		29a. Contiller Scentifying Phys	ucians To the best of m	y knowledge, de	atti posurrud at tra	s terro, data are	d place, and devite the	cause(s) and manner	as stated.
Ne Hos 24 h	Medicai		ier: On the basis of exa and manner stated.						
To th To th comp	ž	29b. Signature and title of certifier	Λ	R		ense number	r in	29d. Date signed (Mo	
, , , , , , ,		-1. to () c	mell	15	-1 \mathcal{D}	55	510	Jeptem be	19702
GHVA		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Typ	e, Print)	Plan	No.	a/1 110	19702
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	*	, 40	144 (2		, , , ,
Regist		SEP 0 7 2007	Moure S.	boarde	الر				

DHMH 17 Rev 1/2001

			State of Maryland / D	epartment of F		lental Hygie	^{ne} 2007	30442
***			Decedent's Name (First, Middle, Last)		Dou.ii	2. Date of Death		3. Time of Death
	Physici /Medic		Robert Harvey Hayden,	III		sep. 7,	^{Day} 2007 Year	2:30 A M
1	Examin		4a. Facility Name (If not institution, give street and number)		r Location of Death		4c. County of Deat	
			7201 Travertine Dr. Apt. 20 5. Social Security Number 6. Sex 7. Age (In yrs. last birth		sville	O. D. A (Dist.	Balti	
	Funeral Director		10 to 10 to	rs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye tober 14,	9. Birt 1953 M	hplace (State or Foreign untry) aryland
A 24	the same		Usual Residence of Decedent		00	CODEL 14,	1755 11	aryrand
200	show	lan.	10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
M	28a-f s	ecto		esville				1 ☐ Yes 2 ☐ No
ž.	a or i	Funeral Director	10e. Street and Number 7201 Travertine Drive , Apt. 206	10f. Zip Code	208	10g.	Citizen of What Co USA	untry?
dtagt	ms 23	nera		13. Was Decedent of H		ecify Yes or No-	14. Race - Ame	rican Indian,
9	or Ite	Fur	11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give	If Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexican, Puerto I Specify:	Rican, etc.)	Black, White	e, etc. White
d 21215-0036 filed within 72 hours after death with the Maryland	ural",	Completed by	3 Wildowed 4 Li Divorced Year or Dates:				Зреслу.	
15	"nat edica	lete	(Specify only highest grade completed)	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of workind)	ng 16b	. Kind of Business/	Industry
2121 d within	jiene. r thar the M	omp	Elementary/Secondary (0-12) College (1-4or 5+)	Technician	7		Electro	nics
nd ;	al Hyg	ge C	17. Father's Name (First, Middle, Last)			(First, Middle, Maid		
yla	ind Mental s marked o umatic eve	To Be	Robert Harvey Hayden, Jr.			nabelle Si		
Maryland	10 - 10			Mailing Address (Street				
. 1 and	f Healt Item 2 other			11 Travertin Disposition (Name of a crematory or other place)			Pikesvil.	
Baltimore,	0		Durial 2 Dolemation 3 Definition State		!		·	
Baltii permit.			21. Signature of Funeral Service Licensee M00945	Shost Cemete			ssue,Mary	Land
n s	SE E S		Bard C. Echil		Mary's Ave			646
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dyin	ig, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition resulting in death) a. My o Card (al In	farction	1		Onset and Death 5 minutes
	Medical xaminer		Due to for as a consequence of	Atherosc	/			→7
		er	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	therosc	erosis			1 years
cuted	id ansit	Examiner	that initiated events \blacksquare 6 1 1 1 1 2 1 1	demia				30 years
e exec	hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
ox 68/60, certificate be executed	physic s the b	dical	d					
BOX 5 ath certific	attending p	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy				22d Date of deli	
. 50	d for u	iciar	in the past 12 months? 1 Ves 2 No 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	!		23d. Date of deli Month	Day Year
at te	been signed by the should be detached	hys	9□Unknown					
	igned be de	by F	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause give	en in Part I.			the cause of death?
ecords, law requires t	een s hould	ted				1 Tes	2 No 3 Pro	obably 4 □Unknown
The law	2 5	Completed				24a. Was an autopsy performed	nrior to c	topsy findings available ompletion of cause of
	n. After this certificate ha funeral director, page		25. Was case referred to medical		00.01	1 Yes 2 Y	No 1 ☐ Yes	2 1 No
(C)	s cert direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	patient 3 DOA Othe	er: 4 ☐ Nursing Hon		6 DOthor (Spor	26.0
or Property of the Property of	ter thi		27. Manner of Death 28a. Date of Injury 28b. Tir	me of 28c. Injury	vat i 2	28d. Describe how in	njury occurred	ary)
SIO	eath. Ior; A the fu	catic	2 Accident investigation	M 1 🗆	Yes 2 □ No			
UIVISION I or Attending	Direct Direct in by	Certification:	4 Homicide 28e. Place of injury - At home, farm building, etc. (Specify)	1, street, factory, office	2	28f. Location (Street City or Town, St		ral Route Number,
Spital	neral rilled		29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occurred at the tir	ne, date and place, a	and due to the cause	e(s) and manner as	stated.
he Ho	within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.	or investigation, in my o	pinion, death occurre	ed at the time, date	and place, and due	to the cause(s)
10	To the	Ž	29b. Signature and title of certifier	29c. License			Date signed (Month	
•			> Hera M Monford MD	DO	018416	9	17/200	7
2	22		30. Name and address of person who completed cause of death (Item 23a) (Tylindright Court of the	ype, Print)	01	, 41	A	100-
(1)	ا بہر (آ\ Sta	te	31. Date filed (Month, Day, Year) 32. Posistrar's Signature	155 Falls	Kd Lut	nerville	1700	4093
	Registra		SEP 1 0 2007 Seem &	Sparle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1- State Registrar amended 9-05-2007/item #21/wcridificate of Death 30443 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10:33 01 2007 George V. Hitchens /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HICHMICO PENIASULA KLAIDHAL MEDICAL Sallsburg CINTA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2□ F Days Min 81 Director 218-20-8312 Delaware 3-4-1926 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 X No Director Delaware Sussex Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29136 Discountland Road 19956 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 2 Specify: White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Is marked other than College (1-4or 5+) Owner/ Frame Shop Framing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Mental I Louis D. Hitchens Blanche Short 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Roy Jones (son in law) 114 The Villas Laurel, De. 19956 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St.phillips Epis Ch. 9-7-2007 Laurel, Delaware 21. Signature of Funeral Service Licens Holly Short-Hannigan, Short, Disharoon F.H. 700 West St. Laurel, De. 19956 Character 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1etastatic Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-trar Due to (or as a consequence of): attending physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Honknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed?

1 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ပ 2 □ J. We 1 patient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760. 018-20-

Maryland 21215-0036

Baltimore,

(e Will IVX

State Registrar

Medical

29a. Certifier

HNUPAMA

29b. Signature and title of certifier

and manner stated.

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 & Carroll St. Solisbury MD 21801 VARADA KAJAN

IMD egistrar's Signature

	1 - For State Registrar	State of Ma	-	epartment Certificate			ientai Hy	rgiene Reg. N2 0	07	304	+44
	Decedent's Name (First, Michael Control of the	ddle, Last)					2. Date of De	eath		3. Time o	of Death
Physician /Medical	Emile Elias	Joseph					Month Septeml	ber 6,	200 7	2:43	рМ
Examiner	4a. Facility Name (If not institu	tion, give street and number)		4b. City, 7	Town, or Locati	tion of Death		4c. Cour	ty of Death	1	
and particular tracks	Suburban Hos	-		Bethes		-1041(1				ontgom	
uneral irector	5. Social Security Number 577-03-8022	6. Sex 7. Age	(In yrs. last birth) 90 Yr	Months	Days Hou	nder 24 Hrs. urs Min.	8. Date of Bi	rth ay, <i>Year)</i> 1, 1 917	Col	nplace <i>(State i</i> <i>intry)</i> hingto :	
20101	Usual Residence of Decedent								1100		, 50
ta T	10a. State 10b. Coul	nty	10c. City, Town of	or Location						10d. Inside C	
any injury or other traumatic event, the Medical Examiner must be notifiled at once. To Be Completed by Funeral Director	Maryland	Montgome	ry		nsingt	on					2 X No
j	10e. Street and Number 4107 Mitsc	ham Caumt		10f. Zip	Code 2089	0.5		10g. Citizen o	USA	intry?	
Funeral	11. Marital Status	12. Was Decedent E	ever in U.S.	13. Was Deced If Yes, spec			ecify Yes or N	0- 14. R		ican Indian,	
by Fur	1 Never Married 2 Nover	If Yes, Give	lo	If Yes, spec 1 ☐ Yes 2			Rićan, etc.)		ack, White cify: Wh		
Completed	15. Deced (Specify only hig	lent's Education hest grade completed)	1 (0	ecedent's Usua Give kind of wor	k done durina i	most of working	ng	16b. Kind of	Business/I	ndustry	
am Jam	Elementary/Secondary (0-12		+)	ife. DO NOT us	· · · · · ·						
ပိ	17. Father's Name (First, Midd	[5+		Chie	ACCO		(First, Middle	Financ		anagem	ent
To Be	Elias Joseph	,,					na Nas				
-	19a. Informant's Name/Relation Edith K. Jo		19b. N	Mailing Address				per, City or Tow Kensing			95
	20a. Method of Disposition	n 3 □Removal from State	20b. Place of D	isposition (Nam crematory or ot	ne of ther place)	1	ate	20c. Location	n - City or 1	Town, State	
	4 □ Donation 5 □ Other	(Specify)	Parklaw			rk 200				Mary1	and
ouce.	21. Signature of Funeral Servi	. /. /						al Home		ring,	MD 20
104	shock, or heart failure. I	or complications that caused ist only one cause on each line	e.	_						Approxima Interval Be Onset and	te tween Death
cian Iícal	Immediate Cause (Final disease or condition resulting in death)		NGES		HER	tat	FAI	LUR	5		
ner		Due to (or as a	consequence of)	11401	IA						
dical Examiner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	Consequence of)		0()(
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C									
Ä	resulting in death) Last	Due to (or as a	consequence of)	t							
dical		d					_				
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ciar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at	2 Fetal death	3 ☐ Ectopic pre 5 ☐ Other (spe					Month		Year
hvs	9 Unknown	9□Unknown									
d by P	Part II. Other significant cond	litions contributing to death bu	t not resulting in th	ne underlying ca	use given in P	Part I.		tobacco use co	-	the cause of obably 4	
lete		./*					24a. Was	an 24t	. Were au	topsv findings	available
Completed		;					auto perf	ormed2	death?	topsy findings ompletion of c	ause of
Be	25. Was case referred to med	cal			26. P	Place of Death				240 140	
일	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 ER/Outp	atient 3 DO				idence 6 □C	ther (Spec	eify)	
l. E	27. Manner of Death 1 Natural 5 □ Pen	28a. Date of Injury ding (Month, Day	y 28b. Tin <i>Year)</i> Inju	ıry	Bc. Injury at Work?	2		how injury occ			
cati	2 ☐ Accident inve	stigation	At home form	M	1 □ Yes 2	-		(2)			_
artifi		28e. Place of injurbuilding, etc.	ry - At nome, farm . <i>(Specify)</i>	i, street, factory	, office	2	28f. Location (City or To	(Street and Nur wn, State)	nber or Ru	ral Route Nun	nber,
Medical Certification:	29a. Certifier 1 Certification (Check only one)	ying Physician: To the best o cal Examiner: On the basis of and manner stat	examination and/	death occurred a or investigation,	at the time, dat in my opinion,	ite and place, a	and due to the	e cause(s) and , date and plac	manner as e, and due	stated. to the cause((s)
Medical Certification	29b. Signature and title of cert		ieu.	29c.	. License numb	ber		29d. Date sign	ned (Month	, Day, Year)	
		(man)	3-1-3	MA	200	5712	24		7 10		
1		Cory			DUV.) [[- { I	2 1	/ "	_ /	
5)41	30. Name and address of pers Truong Bao,			/pe, Print)					/		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year SUSIE ohnSon 14945 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hursing Centre Blue Baltimore Point If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 29, 1 Birthplace (State or Foreign Country) Hours Days 1 ☐ M 21 F Months 87 VA. 227-07-2717 Jan. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Director VA Ashburn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44517 Blueridge Meadows Dr. 22147 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No þ Specify: Specify: 3 Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Housewife None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna Jefferson Bernard Moore ၉ 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44517 Blueridge Meadows Dr. Ashburn, VA. 22147 19a. Informant's Name/Relationship (Type. Print) Spurgeon F. JohnsonJr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 9-8-2007 Brentwood, MD. 21. Signature of Funeral Pervice 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 11 4217 9th St. N.W. Washington, DC 20011 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Therosclero Due to (or as a consequence of): (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 Tyes 2 🗌 No

The law requires that the death certificate be executed sician and burial-tran Division or Vital Records, P.O. Box 68760 the attending pl for use as t sate has been signed by the a page 2 should be detached certificate Hospital or Attending Physician: funeral director, s after us. ral Director: An

Physician/Medical Completed by Be Certification: To

filled in by

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hyglene. anti: If liem 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1
Department of H
Important: If ite
any Injury or oti

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

within 24 hours a

State

N Klacem

6 ☐ Could not be

determined

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29c. License number

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year, 32. Registrar's Signature

Registrar

Medical

30446 State of Maryland / Department of Health and Mental Hygien20071 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Year **Physician** 10 40 aM 2007 30 Liselotte Jordan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Home of Greater Washington Rockville Montgomery Hebrew If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** 1 □ M 2 🖾 F May 05, 1919 Czechoslovakia 88 Director 550-66-0042 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other then "natural; or items 23a or 28a-f ehow promiting or other traumatic event, the Madical Esserti art must be notified at once. 10a State 1 ☐ Yes 2 ☑ No Director Montgomery Village Maryland Montgomery 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number United States 20886 19411 Brassie Place #201 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes 2 🙀 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: þ White 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Daniela Marky Janos Ebinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Evamaria Jordan Camello/Daughter Rua Dr. Mario Freire #56; Sao Paulo, Brazil 05692 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 9/5/2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licentee Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part / Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) cardio-respiratory Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physicien end detached for use es the burial-transit Exami Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown cate has been signed by pege 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Cret 1 Yes 2 No 3 Probably 4 Unknown enosis Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 20 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director; 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death 28b. Time of Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2005362 8-30-07 3 Prim Selya veder ele HX Karser Leomanant f death (Item 23a) (Type, Print) 30. Name and address of person who completed cause eson

State Registrar 31. Date filed (Month, Day, Year)

gegistrar's Signature

32.

State of Maryland / Department of Health and Mental Hygiene, 30447 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 200^{Year} ALICE D. V. JAMES SEPT. 1, 9:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 410 Girard Street, Gaithersburg MONTGOMERY If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Feb. 14, 1937 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 M 2 TF 70 Yrs. Director 217-36-5274 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD 1√2 Yes 2 □ No Director Montgomery Rockville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 201 Poplar Spring Road 20850 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien Important: If item 27 is marked other tha any Injury or other traumatic events. Cook 12th H.E.W. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Stewart Nellie Claggett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 201 Poplar Spring Rd, Rockville, MD 20850 Llyod N. James (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ash Memorial Cem 9/7/07 Sandy Spring, MD 4 □ Donation 5 □ Other (Specify) 21. Sonatura of Ineral Service License 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NECK Due to (or a a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ase If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Yes 2√ No 9 Unknown 4□Pregnant at time of death 5 Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate 1 Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Daughter's Other: 4 Nursing Home 5 Residence 6 State (Specify) Hospital: 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t Hospital or Attending 1 🗔 Natural 5 Pending investigation Injury in 24 hours and the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. the To the I To the within 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Bauner, 9 - 4 - 07D060335 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Dr, #327, Olney, MD 20832 Barren, M,D31. Date filed (Month Day, 32. Rigistrar's Signature Year) State 6 2007

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30448 Reg. No.2 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death c 3, 2007 **Physician** Anna September Joseph 4:55P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens at Riderwood Village Silver Spring Prince George's 8. Date of Birth (Month, Day, Year) May 8, 1921 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Pennsylvania 184-18-1154 86 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Maryland Prince George's Silver Spring Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3148 Gracefield Road,#423 20904 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No if Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Bolcheck Susan Brinsko 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Joseph -husband 3148 Gracefield Road,#423 Silver Spring, Md. 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State Gate of Heaven Cemetery 9/7/2007 Silver Spring, Maryland 4 Donation 5 Dother (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Diabeks Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed for use as the burial-trai attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death Year Day 5 Other (specify) signed by the a d be detached for 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ₩0 24a. Was an autopsy performed certificate 2 **J** Mc funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 □ Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Certification: 1 Natural Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.O. Box 68760, Division or Vital Records,

10

State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOVEEN J. PUTHUMANA 3110 GRACEFIELD ROAD SILVER SPRING MD 20904 31. Date filed (Month Year)

gistrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D59524

29d. Date signed (Month, Day, Year)

September 5, 2007

			For State Registrar	State o	of Marylar	id / Depa	artment o <i>rtificate d</i>	f Healti	n and N	lental Hy		007	30449
١,		-11	Decedent's Name (First, Middle, La.	st)			- Involuto c	77 2041		2. Date of De		00,	3. Time of Death
	Physici /Medic		Jane Stevenso		steit					Month Septem	Day	2007	4:20 PM
	Examir		4a. Facility Name (If not institution, giv	e street and nu	mber)	-	4b. City, Tow	n, or Location	on of Death	_	4c. County of Death		
			Gilchrist Center				Towso				Ba	Ltimor	e
ľ	Funeral Director		5. Social Security Number 6. S 181–14–4723	ex □M 2ĀF	7. Age (In yrs. 89	last birthday) Yrs.	If Under 1 Ye		der 24 Hrs. 's Min.	8. Date of Bi (Month, Da Oct.	th ay, Yea <i>r)</i> 19, 191	Cou	
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ocation						IOd Inside City I inside
	laryla shor	5	,	i									10d. Inside City Limits 1 X Yes 2 □ No
	the N 28a-f notifie	ect	Maryland Harford 10e. Street and Number		Hav	re de	Grace	10			10g. Citizen	- (W/b - + C	
	with Baor the	Funeral Director	814 Market Stree	t				1078					•
	ns 23 mus	era	11. Marital Status	12. Was Deci	edent Ever in U	.S. 13.			Origin? (Sp.	ecify Yes or No	United	Race - Americ	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 【X Widowed 4 ☐ Divorced	Armed Fo 1 ☐ Yes If Yes, Gir Year or D	orces? 2 📉 No ve		Was Decedent If Yes, specify (1 ☐ Yes 2 💢			Rican, etc.)		Black, White, city: White	etc.
9	72 ho natur ical B	ted	15. Decedent's Ec	fucation		16a. Dece	dent's Usual Oc	cupation		t	16b. Kind of	Business/In	dustry
2	thin 7 se.	Completed	Elementary/Secondary (0-12)	College (1	1-4or 5+)		kind of work do DO NOT use re			ing			
2	ed wi ygier ner th	ဦ	12	4		Execu	itive Se					rance	
п	be fill ntal H nd oth	Be	17. Father's Name (First, Middle, Last, Arthur Milton							e (First, Middle	, Maiden Surr	ame)	
3	Mer Mer narke	٩				T				Murphy			
Maryland	12 sk thand 7 Is n traun		19a. Informant's Name/Relationship (ng Address (Str						
e,	1 and Healt em 2		Marsha S. Jackst 20a. Method of Disposition	eit/Dau		409 (Girard Spitton (Name of	Street			grace,		
altimore,	ages int of t; if it		1X Burial 2 ☐ Cremation 3 ☐		State	cemetery, cre	matory or other Schwenki	place)		ember	Worces	ter,	own, State
표	artme artme ortani injun		4 ☐ Donation 5 ☐ Other (Specification of Septice Sept	1)							Pennsy	<u>lv</u> ania	l
Ba	Dep Impo		1/1///			12	2. Name and Ad	Main	Stro	uch Fur	eral H	ome	y1and21901
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that c	aused the deat	h. Do not ent	ter the mode of	dying, such	as cardiac	or respiratory a	rrest,	t, Mar	Approximate Interval Between
	Physician /		snock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	oach line. ON GU (or as a conseq	E CAI							Interval Between Onset and Death MONTHS
35.2	Examiner			. –	(0. 00 0.004	20.100 01).							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Duá to i	(or as a conseq	uence of):							
	icate be executed physician and the burial-transit	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C									
Ö,	e exe ian aı ırial-t	Ë	resulting in death) Last	Due to	(or as a conseq	uence of):							
8760,	ate b hysic the bi	dical		.d									
ဖ	ertific ling p	Mec	IF FEMALE:					- 1				1	
.O. Box	The law requires that the death certific to has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣No 9 ☐ Unknown	1☐Live b	tcome pf pregna pirth 2 Peta nant at time of d	ideath 3□	Ectopic pregna Other <i>(specify</i>					Date of delive Month	ery Day Year
ď,	s that	by P	Part II. Other significant conditions of	ontributing to de	eath but not res	ulting in the u	nderlying cause	given in Pa	rt i.	23e. Did 1	obacco use co	ontribute to th	ne cause of death?
ğ	equire en sig	edk								1 🗆	Yes 2□ No	3 ☐ Prob	ably 4 mknown
Records,	law re as bed 2 sho	Completed								24a. Was		b. Were auto	psy findings available
	The lav	m o								auto perfo 1∐ Yes	ormed? 2.22No	death?	mpletion of cause of
Vital	ilcian; The certificate ha ector, page	Bec	25. Was case referred to medical examiner?					26. Pla	ace of Death	(Check only o		I Les	2 140
	is is	To	1 ☐ Yes 3 ♣ No	Hospital: 1 □ I	npatient 2	ER/Outpatier	it 3□ DOA	Other: 4 🗆	Nursing Ho	me 5 ☐ Resi	dence 6	ther (Specif	HOSPICE
Division or	ding Ph h. After th funeral		27. Manner of Death 1 ► Natural 5 ☐ Pending	28a. Date ((Mont	of Injury th, Day Year)	28b. Time of Injury	28c. li	njury at Vork?		28d. Describe	how injury occ	urred	
Sio	tendi eath. tor: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be					☐ Yes 2	□No				
\leq	or At after d Direc in by	E	4 Homicide determined	28e. Place buildi	of injury - At ho ng, etc. (Specify	ome, farm, str (/)	eet, factory, offi	ce	1	28f. Location (Cify or To	Street and Nur vn, State)	mber or Rura	I Route Number,
_	spital ours a neral I		29a. Certifier 1 Certifying Ph	velelan. To the	hoot of my kno	uladaa daat	a accurred at the	- 61-0-0 -1-6-	and alone				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Examone)	iner: On the ba	asis of examina ner stated.	tion and/or in	vestigation, in n	ny opinion, o	death occur	ed at the time,	date and plac	manner as s e, and due to	tated. the cause(s)
	To vit	- 1	29b. Signature and title of certifier	X	/ -			ense numbe			29d. Date sign		
•				1)/	1			470	70		SEPTE	MEER	0,2007
	5		30. Name and address of person who DANIEUE DOBERMA	NI MD	6565	23a) (Type, V CHA	Print) RUS ST	. 84	TE 21	6 BA	TIMOR	E. M.	21204
e e	Sta Registra	te	SEP 0. 7 2007	12. R	egistrar's Signa	ture spec	w						

Certificate of Death

2. Date of Death

Year

8:45

Birthplace (State or Foreign Country)

Pennsylvania

10d. Inside City Limits

1 ☐ Yes 2 No

MD 20901

Approximate Interval Between Onset and Death

Day

Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

2007

USA

Specify.White

14. Race - American Indian,

Black, White, etc.

1. Decedent's Name (First, Middle, Last)

Registrar

Genevieve Wroblewski, M.D.

31. Date filed (Month, Day, SEP 1 0 2007 6001 Muncaster Mill Road, Rockville, MD 20855

State of Maryland / Department of Health and Mental Hygien 🗸 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Gertrude September 5, 4:05p M King 2007 Henrietta /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Bethesda Montgomery

9. Birthplace (State or Foreign Country) Bartholomew House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year, **Funeral** Days 1 □ M X 🙀 F Months 214-10-5567 94 Maryland Director 6, Usual Residence of Decedent with the Manyland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If itsm 27 is marked other than "natural", or itams 23e or 28e-1 show any injury or other traumatic event. The Wadigal Exament into the colline and once. 1 ☐ Yes 2 🖾 No Bethesda Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6904 River Road 20817 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surmame) Be J. Henry Wolfe Mary Ann Knouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denis J. King/Step-son 11224 Waycross Road, Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Gate of Heaven Cemetery 2007 M⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Silver Spring, Maryland 2007 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. . Key Skile 500 University Blvd, W, Silver Spring. MD 20901 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Lung Cancer 1 year resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Underlying that initiated events Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Box 68760 the attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death for in the past 12 months? Month Year Day 5 Other (specify) P.0. 1 ☐ Yes 2 🔊 No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à pe 3 Probably 4 Unknown XYes 2 □ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Assisted 1 ☐ Yes 200No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 12 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident the Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 - Homicide To the Hospitel of within 24 hours at To the Funerel D pelli 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier 400 D15901 September 7, 2007 30. Name and address of person who compleyed cause of death (I)em 23a) (Type, Print) Michael Grady, 4201 Cathedral Avenue, NW, #114W, Washington, DC 20016 M.D. 31. Date filed (Month, Day, Year) SEP 1 0 2007 32. Registrar's Signa

DHMH 17 Rev 1/2001

State Registrar

		For State Registrar			tificate of			g. No.			
Physicia	an	 Decedent's Name (First, Middle, Last) Lester Edward Kistl 	or				2. Date of Death Month Sept	8 2007	3. Time of Death 2:20 P		
/Medic	_	4a. Facility Name (If not institution, give street			4b. City, Town,	or Location of Dea		4c. County of Death			
Examin	eı	Bluepoint Nursing &	Rehab		Baltin	nore		Baltimore City			
Funeral Director		5. Social Security Number 188–12–5076 6. Sex	7. Age (In yrs	. last birthday) 4 Yrs.	If Under 1 Year Months Days			Year) 9. Birth 923	place (State or Foreigintry) PA		
* =		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limit		
le ho	į	MD Washingto	on .	Hagerst	own				1X Yes 2 □ N		
r 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ıntry?		
23a o	a D	606 Potomac Avenue	#1		2174	1 0		US			
Department of Health and Mental Hygiene. Important: or items 23s or 28s-f show important: if item 27 is marked other then "natural; or items 23s or 28s-f show eny injury or other traumatic event. In Modical Examination traumatic event.	d by Funeral	1 Never Married 2 Married	Was Decedent Ever in I Armed Forces? I X Yes 2 □ No If Yes, Give Year or Dates: 194	3-45	1 ☐ Yes 2 X No	Specify:	Specify Yes or No- irto Rican, etc.)		hite		
"natu	Be Completed	15. Decedent's Education (Specify only highest grade control of the mpleted)	(Give	dent's Usual Occu kind of work done DO NOT use retin	during most of we	orking 1	6b. Kind of Business/	ndustry			
iene.	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		inter Fo	*		U. S. Gov	ernment		
othe vent.	Se C	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle, M	aiden Sumame)			
Menta arked atic e	To E	Joseph William Kist					iche May G				
th and 7 is m traum		19a. Informant's Name/Relationship (Type, Edward L. Kistler						City or Town, State, 2 n, VA 2440			
item 2 other		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other pl	1		0c. Location - City or			
nent o int: if iry or		1 Burial 2 ☐ Cremation 3 ☐ Remarks 4 ☐ Donation 5 ☐ Other (Specify)	Ce	-	n Mem Pa		12/2007	Hagerstown	, MD		
Departn imports eny inju		21. Signature of Funeral Service Licensee	68		Name and Add	C		Minnich Fu erstown, M			
*		23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one c	ons that caused the dea	ath. Do not ent	er the mode of dy	ing, such as cardi	ac or respiratory arre	st,	Approximate Interval Between Onset and Death		
physicien end immers the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
ed by the attending pl detached for use as t	Physician/Med	in the past 12 months?	If yes, outcome of pregi 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	taideath 3□	Ectopic pregnan Other (specify)	су		23d. Date ol del Month	very Day Year		
E 0	þ	Part II. Other significant conditions contrib	uting to death bul not re	sulling in the u	nderlying cause g	iven in Part I.		acco use contribute to s 2 □ No 3 □ Pr			
cate has been si page 2 should t	Completed						24a. Was an autopsy perform	ed? prior to death?	topsy findings availa completion of cause of		
director, pag	Be	25. Was case referred to medical examiner?	sital:				eath (Check only one)			
this aldi	<u>ا</u>	I Tes 2 X No	ntal. 1 ☐ Inpatient 2 (8a. Dale of Injury	ER/Outpatier 28b. Time of	IL SLI DOA		Home 5 Resider	nce 6 Other (Spec	cify)		
r death. octor: Alter by the funer	t e	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	W	ork? □Yes 2□No	200. Describe no	w injury occurred			
s after deat if Director: id in by the	Certification:	2 Could not be	8e. Place of Injury - At building, etc. (Spec		eet, lactory, office	Э	28l. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,		
within 24 hours after d So the Funerel Direct completely tilled in by	edical (29a. Certifier (Check only one) 1 Certifying Physici 2 Medical Examiner									
within 2	ž	29b. Signature and title of certifier	2 M		29c. Lice	nse number	29	d. Date signed (Mont	n, Day, Year)		
1,X		Howard &	5. Oken	M.D		21680		9/10/07			
1	1 1	30. Name and address of person who comp	leted cause of death (Ite	em 23a) (Type,	Print)						
1+1		Howard B. Cohen	MD 6717	Dowle :	II+ a A	D ~ 1 ⊢ .	MD 91'	715			

State

Registrar
DHMH 17 Rev 1/2001

GENIEVE

31. Date filed (Month, Day, Year) SEP 1 0 2007 6001 MUNCASTER MILL RD, ROCKVILLE MD 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD,

32. Registrar's Signature

WROBOEWSKI

07-06835 Jerry William Kent Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

rry william Kem	1-	- For State Crimar yield / Depa	tificate d	of Death		R	eg. No. 20	107 3045
Physiciar		eqistrar 1. Decedent's Name (First, Middle,Last)				2. Date of Dea Month	Day Year	3. Time of Death
edical Examin		Jerry William Kent				Septembe	er 3, 2007	0529 hrs
	4	4a. Facility Name (if not institution, give street and number)		4b. City, Town, o	r Location of	f Death	4c. County of De	
	H	Prince George's Hospital		Cheverly			Prince Geor	
Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. Ia	ast birthday)	If Under 1 Ye			rth(MM/DD/YYYY) g.	Birthplace (State or reign Washington
Director		213-94-7530 1XM 2F 41		/rs. Months Da	ys Hours	July 2		Country) DC
· seconds · sec · con get to fee ·		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loc	cation				10d. Inside City Limits
w any	ı							1 X Yes 2 No
Aaryland 28a-f show 1 at once.	₫٢	Maryland Prince Georges Bow. 10e. Street and Number	TE	10f. Zip Code			10g. Citizen of What C	ountry?
Marr r 28a	Director			20715		4.1	USA	
th the 23a o		3803 Corbett Place 11. Marital Status 12. Was Decedent Ever in U	S 13 1		lispanic Orio	jin? (Specify Yes or N		merican Indian, Black,
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		1 X Never Married 2 Married Armed Forces?		If Yes, specify Cub.	an, Mexican,	, Puerto Rican, etc.)	White, et	à.
or it	ᇍ	3 Widowed 4 Divorced If Yes, Give Year	1	Yes 2X N	lo specify:		Specify:	White '
s after	<u>ا</u> ھ	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation (Give	kind of work done	16b. Kind of Busine	
hour "nate	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	during	most of working li	fe. DO NOT	use retired) .		
136 hin 72 e. than edical	휣	11	Tow T	ruck Dri	ver	- 4.	Automoti	ve
5-003 iled withi Hygiene I other th	하	17. Father's Name (First, Middle, Last)			18.Mother	's Name (First, Middle	, Maiden Surname)	
215 e file tal Hy eed o	Be	Ronald Eugene Kent, Sr.			Cathe	erine Loui:	se Jones	
21215-0036 21215-0036 Mental Hygiene. marked other than marked other than	10	19a. Informant's Name/Relationship (Type, Print)					umber, City or Town, S	itate, Zip Code)
MD d 2 sho lith and n 27 is	-	Ronald E. Kent, Sr./ Father	3803	3 Corbett	Place	e Bowie, M	D 20715 20c. Location - Cit	Las Tours State
e, Pand and Health item	- 1	20a. Method of Disposition 20b.	Place of Dis	position (Name of other place)	cemetery,	Date	20c. Location - Cit	y or Town, State
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. it: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner.	- 1	1 Burial 2 X Cremation 3 Removal from State	Metro	rother place) politan atory		9/7/2007	Alexand	ria, VA
Baltimore, MD 2121 permt. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event.	+	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	2	2. Name and Addre	ess of Facilit	Robert E.	Evans Fun	eral Home
Balt perm t. Deperti	ij	KUTT		16000 Ann	apoli	s Road Bow	ie, MD 207	15
Physician		23a. Part I. Enter the disease, or complications that caused the deat failure. List only one cause on each line.	h. Do not en	er the mode of dyin	ng, such as o	cardiac or respiratory a	arrest, shock, or heart	
Medical	-	Immediate Cause (Final disease a. Multiple Injuries						Death
caminer	- 1	or condition resulting in death) Due to (or as a consequence	of):					
		Sequentially list conditions, b.	of):					
	je	if any, leading to immediate Due to (or as a consequence	oi,i.					
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	of):					
'60, zate be executed physician and he burial - transit		d						
e exe	Medical	UNPENDED						
760, cate be physici		IF FEMALE: 23c. If yes, outcome of pre 23b. Was decedent pregnant in the		F-1-1 d-ath	3 Ecton	oic pregnancy	23d. Date of de Month	Day Year
68 certification	ä	23b. Was decedent pregnant in the past 12 months?	death 5	Fetal death Other (Specify)	5	no programa,		
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown g Unknown	0	J Outon (Opening)				
O. E			t resulting in	the underlying cau	se given in F			ute to the cause of death?
P.C	by							Probably 4 Unknown
ds, equir een s	Completed					24a. W	as an 24b. We	ere autopsy findings available or to completion of cause of
COT law I has b	ηdu					pe 1 ✓ Ye		ath? ✓ Yes 2 No
Re The ficate f, pag	ပ္ပ	25. Was case referred to medical		26.P	lace of Deat	h (Check only one)		
ician ician s certi	Be	examiner? Hospital: 1 Innatient 2	✓ ER/Outpa	atient 3 DOA	Other ₄	Nursing Home 5	Residence 6	Other:
of V Phys er thi	2	1 Yes 2 No 28a. Date of Injury			Injury at Wo	rk? 28d. Descri	be how injury occurred	llision
nding h. Aft	Ö	1 Natural 5 Pending Sep 3, 2007	0423 hr	rs 1	Yes 2	✓ No Driver au	to fixed object co	MISION
isio Atter r deal rector by th	icat	2 Accident Investigation 28e. Place of Injury - A	t home, farm	street, factory, offi	ice building,	etc. 28f. Locatio	on (Street and Number n, State)	or Rural Route Number, City
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rate death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	Suicide 6 Could not be determined (Specify) Park/Rec	creation A	rea		Moyler / M	adley Lane , Bowie	, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi			edge, death	occurred at the tim	e, date and	place, and due to the o	cause(s) and manner a	as stated.
thin 2 the 1 the 1	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	n and/or inve	stigation, in my opi	nion, death	occurred at the time, d	ate and place, and du	e to the cause(s)
P N E S	ŝ	29b. Signature and title of certifier			cense numb	er	1	d (Month, Day, Year)
		Marking Malkery		0	.C.M.E.		September	3, 200 <i>1</i>
		30. Name and address of person who completed caus of death (II	em 23a)					
apt		Margarita Korell MD. Assistant Medical Exam	niner 1	11 Penn Stree	t, Baltimo	re, MD 21201		
	tate		nature /	bout	ì			
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State of Maryland / Department of Health and Mental Hygiene, 30455 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2007 DARLA **KERNS** 09 2248 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 236-62-5605 Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director WV Morgan Paw Paw 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 352 McCoole Avenue 25434 USA Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛂 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 1 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Manufacturing permit. Pages 1 and 2 should be filed I Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, tit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles A. Gordon Margaret Shanholtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald H. Kerns / Husband P. O. Box 355 Paw Paw, WV 25434 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Camp Hill Cemetery 9/7/2007 Paw Paw, WV 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Kimble Funeral Home 188 Moser Avenue Paw Paw, WV 23a. Part 1. Soler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PSAGOSTO ARTERY DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed Exami burial-trar Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 2 No 1 ☐ Yes 3 Probably 4 ☐ Unknown FAILURE Completed 24a. Was an autopsy performed?
1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After . To the Hospital or Attending within 24 hours after death. To the Funeral Director; After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D33280 5 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUNIL GUPTA AVE CUMBE 32. Regionar's Signature CUMBERLAND MD 21502 625KENT 31. Date filed (Month, Day, Year) State SEP 1 1 2007

Registrar

VOID

CERTIFICATE

2007-30456

SEE

CERTIFICATE #

2007-31913 deceased fin Khobod

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month AUG 28^{Day} 2007^{Year} **Physician** CARROLL O. LINEBAUGH, JR. 9:25 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 201-16-7041 1 XM 2 ☐ F 82 Pennsylvania Director Oct 01, 1924 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ıral", or items 23a or 28a-f show I Examiner must be notifled at MD Anne Arundel Davidsonville 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21035 USA 2758 Swann Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WW II 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed ed other than "natu 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief Petty Officer U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Virginia Reid Carroll O. Linebaugh Sr 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 450-A Man-O-War Court, Annapolis, MD 21409 John E. Rothamel/ Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. Sept. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, MD MD Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Fur)eral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral 495 Gov. Ritchie Hwy, Severna Park, MD 2114 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has be rector, page 2 s autopsy performed 2 🔀 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28h. Time of 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation 1 Yes 2 No Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29/2007 MD 35.087697 (OH) 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL BETHESDA MD 20889-5600 JONATHAN P. PEARL MC LCDR USN 31. Date filed (Month, Day, Year) State SEP 0 6 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30458 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** W. Lyles September 2007 3:40 P M Herman /Medical 4a. Facility Name (If not Institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Hospital Cheverly 8. Date of Birth (Month, Day, Jan 21 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1√2 M 2□ F Washington, DC Director 578-18-3224 90 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at MD Prince George's Landover 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 7114 East Cedar Street 20785 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Black Specify Completed by 3 Widowed 4 Divorced : If item 27 is marked other than "natural", or other traumatic event, the Medical Exa Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Engineer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be finance had Mental H thealth and Ment tem 27 is marked Herman Lyles Sarah Cooper 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Pearl Lyles/Wife 7114 East Cedar Street Landover, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 19/7/2007 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Fatal Cardiac Arrhythmia resulting in death) /Medical Due to (or as a consequence of): Hypertension Sequentially list conditions, Due to (or as a conse juence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed burial-transi Exami and Due to (or as a consequence of) attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the aid be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Diabetes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2√ No 24a. Was an Alzheimers has autopsy performe 1□ Yes 2□ No High Cholesterol or Attending Physician:

Physician Examiner

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records,

Be ۵ ютрletely filled in by the funeral Certification: within 24 hours after death.

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 ☐ Yes 2X No 27. Manner of Death

determined

117 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

5 Pending investigation 6 ☐ Could not be

2 XER/Outpatient 3 DOA 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6, 2007

September

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wendell McConnell M.D. 1221 Mercantile Lane Largo, Maryland 20774

State Registrar

Medical

32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 0 7 2007

State of Maryland / Department of Health and Mental Hygiene 30459 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** Donald Patrick Long 10:15 P M Sept 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 7213 Oliver Street Lanham If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 577-46-0457 1 X M 2 □ F 73 August 8, 1934 Massachusetts Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show r 28a-f show notified at Lanham 1XXXYes 2 ☐ No MD Prince George's Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or a 20706 USA 7213 Oliver Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Supervisor traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental I Pages 1 and 2 should be iment of Health and Menta tant: If item 27 is marked Mary Catherine Law Harold Francis Anthony Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Peggy Joan Long/Wife 7213 Oliver Street, Lanham, Maryland or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page Department o Important: If any injury or Fort Lincoln Cemetery 9/8/07 Brentwood, Maryland 4 □ Dogation 5 □ Other (Specify) 21. Sign and of Funeral Service Livensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 M01491 Michelle re 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCINOMA OF THE PANCREAS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to his reductions. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an , page 2 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mannyr of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Pruneral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 039550 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4850 Forbes Blud Conham, me 20-706 Hall , J. W. D. C. George av 31. Date filed (Month, Day, Year) 32. Registrar's Signatur

DHMH 17 Rev 1/2001

Registrar

SEP 0 7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30460 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** September 5, 2007 Kenneth George Lyle 11:22 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 6311 Woodcrest Drive Anne Arundel County Dunkirk 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Date of Birth (Month, Day, 1**X** M 2□ F Months Days Hours Director 65 Dec. 8, 1941 Washington, DC 220-38-1328 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas pepartment of Health and Mental Hygiene. Inturell, or Items 23a or 28a-f show Important: If fram 27 Is marked other than "ratural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Anne Arundel Co. MD Dunkirk Pages 1 and 2 should be filed within 72 hours after death with the Inent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23a or 28a-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20754 U.S.A. 6311 Woodcrest Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Central Office Technician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lola Herring George Martin Lyle P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 6311 Woodcrest Drive, Dunkirk, Maryland 20754 (Wife) Laila M. Lyle 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept Date 10, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland Resurrection Cem. 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Small 3 months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to jor as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical use as t IF FEMALE If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 1 ☐ Yes 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home within 24 hours after death.

To the Funeral Director: After this 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Mayner of Dath 28b. Time of 28c. Injury at Work? 28d. Deseribe how injury occurred 1 Natural Injury 5 Pending Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 🐧 CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 2 DS2830 we

Registrar

DHMH 17 Rev 1/2001

State

900 Bestage Road #300

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wer

7 2007

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygier 0 17 30461 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 9:00 am September 2007 1 Robert Joseph Ludwig /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Potomac Valley Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 23, 1922 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number 6. Sex Days **Funeral** Months Hours 1⊠M 2□F Yrs 85 Illinois 328-16-5888 Director Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. important: if item 27 is marked other then "natural; or items 23a or 28a-f show any injury or other traumatic avent, the Wedical Eventral must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 K No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20906 3511 Tarkington Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Pueno Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status Black, White, etc. Yes 2 Yes, Give 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♣ No Specify δ Caucasian 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Attorney 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Veronica Mahoney 2 William Henry Ludwig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Louise S. Ludwig - Wife 3511 Tarkington Lane, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, Virginia 4 Donation 5 Other (Specify) 9/6/2007 Gate of Heaven Cemetery 21. Signature of Funeral Service licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final days **Physician** NEUMOU disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Myabthenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 page 2 should be 1 Tyes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 3 DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a: To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month /

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7 2007

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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the Hospital or Attending Physician: within 24 hours at To the Funeral C completely filled i

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State Registrar

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31. Date filed (Month, Day, Year) SEP 1 0 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

for Nalin Plather

29b. Signature and title of certifier

29c. License number

D52289

29d. Date signed (Month, Day, Year)

08-30-07

			For State Registrar	State of Ma	aryianu		tificate of		лептат пу	rgierie Reg. Not	2007	304	63	
	Physici	an	1. Decedent's Name (First, Middle, L	ast)					2. Date of De	eath Day	/ Year	3. Time of	Death	
18	/Medic		Marie Anne M	lay a.k.a.	Mary	y Anne	May		Sept.		007	5:50	рм	
	Examin	er	4a. Facility Name (If not institution, g	ve street and number)			4b. City, Town, o	r Location of Death		4c.	County of Dea	ath		
			Kensington Park					ngton	To 8 : (2)			gomery		
	Funeral Director		5. Social Security Number 6. 411-78-2856 Usual Residence of Decedent	1 □ M 2 😾 F	e (In yrs. la.	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da Jan. 2	ay, Year)		nthplace (State o ountry) cotland	r Foreign	
	anyland show dat	_	10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside Cit		
	the Ma 28a-f s notified	ecto	Maryland Mon	tgomery	Si	lver	Spring 10f. Zip Code			10g Citi	izen of What C		2[X[140	
	h with	Funeral Director	15107 Interlach	en Drive,	‡80 4		2090	5		_	JSA	ounity.		
	deat sms :	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	. 13. W	as Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	0-	14. Race - Am Black, Whi			
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 € Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			☐Yes 2√2 No	Specify:	71110411, 010.7		Specify: W			
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121	d 2 should be filed within 'h and Mental Hygiene. 7 is marked other than "' traumatic event, <u>the Mec</u>	Completed by	Elementary/Secondary (0-12)	College (1-4or s	5+)		rector o				Hote	1		
	filed Hygi other ent, t		17. Father's Name (First, Middle, Las	st)		<u> </u>	rector o	18. Mother's Nam	e (First, Middle	, Maiden		<u>T</u>		
Maryland	ld be ental ked c	To Be	Thomas Hill					Isab	ella Ha	arkes	ss			
ary	shou and M mar umat		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailing	Address (Street	and Number or Ru	ral Route Numb	per, City o	or Town, State,	Zip Code)		
	and 2 saith a 127 is er tra		Ralph A. Mag	y/Husband		1	5107 Into	erlachen	Drive,	*Silv	er Spr	ing, MD	20906	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of	□Removal from State		_	ition (Name of atory or other place han Cremi			[ocation - City o		la	
altii	permit. P Departm Importar any Inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc.											
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			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused y one cause on each li	d the death. ne.	Do not ente	r the mode of dyir	ig, such as cardiac	or respiratory a	arrest,		Approximate Interval Bet Onset and I	ween	
	Physician		Immediate Cause (Final disease or condition resulting in death)	Brain Tur								011001 0110		
	/Medical Examiner		Tooland in double,	Due to (or as			i Iwo							
		ja l	Sequentially list conditions, if any, heading to his module b. Due to for as a consequence of the conditions of the cond											
	uted d ansit	mi.	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events											
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68760,	± 50 €	ledical		d										
.O. Box	requires that the death certi een signed by the attending nould be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal of	death 3	Ectopic pregnancy Other (specify)	′			23d. Date of de Month		Year	
<u>α</u>	w requires that the de been signed by the s should be detached	Completed by Ph	Part II. Other significant conditions	contributing to death b	ut not result	ting in the un	derlying cause giv	en in Part I.				to the cause of d		
Records,	> 0 0	lete							24a. Was	s an	24b. Were a	autopsy findings	available	
Re	ding Phystcian: The law 1. After this certificate has b funeral director, page 2 si	omo				··· -			auto perf 1□ Yes	ppsy ormed? 2 \(\Pi\) No	prior to death?	completion of c	ause of	
Vital	ian: intifica	Be C	25. Was case referred to medical examiner?					26. Place of Deat			1 1210			
or V	Physician: this certific ral director,	ToE	1 Yes 2x No	Hospital: 1 ☐ Inpatie	ent 2□E	R/Outpatient	3□ DOA Oth	er: XX Nursing H	ome 5□Res	idence	6 □Other (Sp	ecify)		
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Division	I or Attencater death Director:	Certification:	4 Homicide determine	4 200. Flace Utili)	ury - At hom c. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location City or To	(Street an own, State	nd Number or F e)	Rural Route Nurr	nber,	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)	Physician: To the best aminer: On the basis o and manner st	of examination	ledge, death on and/or inv	occurred at the tile estigation, in my o	ne, date and place opinion, death occu	, and due to the rred at the time	e cause(s e, date and) and manner a d place, and du	as stated. ue to the cause(s	5)	
	To th within To th comp	Me	29b. Signature and title of certifier	2 - ((29c. Licens				te signed (Mor			
			1 the	(NOGS	/.		D5	3691	S	epte	ember 7	, 2007		
12	-(10)		30. Name and address of person whe Ajay Reddy, 11.					hesda, MC	20817				-	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 0 2007	32. Registr	ar's Signatu	feel)							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Jimmy McKay 2007 September 1, 5:13 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 AM 2 □ F 248-64-1601 69 Director June 19, 1938 Pineland, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 ☐ No Directo Maryland Prince Georges Temple Hills 10e. Street and Number 10g. Citizen of What Country? 4445 23rd. Parkway #102 20748 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 N Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black ð 3 Widowed 4 Divorced Year or Dates "natural", er than "natura" the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest McKay Mary Allen ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4445 23rd. Parkway #102 Temple Hills, Md. 20748 Roberta McKay / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 9/15/2007 Suitland, Md. Cedar Hill 21. Signature of Funeral Service Lig 22. Name and Address of Facility Alexander S. Pope P.A. 5538 Mariboro Pike/Forestville, Md. 1 040100 23a. P. 111 Finter the diserse, or complicity institute aused the death. Do not enter the mode of shick, or heart failur. List only one cause on each limit. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (intenows disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Meumon Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed Exami burial-trar Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ☐Yes 2☐No detached the 9 ☐ Unknown been signed the should be detected to the sh Part II. Other significant conditions conditions to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Sun 1 Yes 2 No 3 Probably 4 denknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 24 and manner stated.

within 2

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of c

Name and address of

son who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

<u> </u>		State of Maryland / Department o 1- For State Registrar 1. Decedent's Name (First, Middle,Last)		Reg. No. 2007 3046
Physici al Exami		MICHAEL ALLAN MARTIN 4a. Facility Name (if not institution, give street and number)	Month	Day Year 1212 hrs
		6 Chestnut Ave.	Boonsboro	Washington
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 214-13-7722 1X M 2 F 33 Yr	Months Days Hours Min.	of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MARYLAN
any.	- 41.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ition	10d. Inside City Limits
. A	L	MARYLAND WASHINGTON	KEEDYSVILLE	1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once.		3725 CHESTNUT GROVE ROAD	21756	U.S.A.
or items	Funeral	1 X Never Married 2 Married Armed Forces? If Yes 2 X No	as Decedent of Hispanic Origin? (Specify Yes Yes, specify Cuban, Mexican, Puerto Rican, etc	White, etc.
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hould b nd Men is marl	2		ng Address (Street and Number or Rural Rout	
2 at 7			CHESTNUT GROVE ROAD,	KEEDYSVILLE, MD 21756 20c. Location - City or Town, State
ges I and 2 of Health If item 2 ther traum	П	1 X Burial 2 Cremation 3 Removal from State	other place)	•
permit. Page. Department o Important: injury or oth			EN CEMETERY 9/13/20	
Depar Impo injur		Paul M. Dean B	AST BUILDED AT BUSINES	6 Old National Pike nsboro, Maryland 21713
ysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.		
Medical caminer		Immediate Cause (Final disease a. Contact Gunshot Wound of Head		Death
		or condition resulting in death) Due to (or as a consequence of):	1 12 25	
	Je.	Sequentially list conditions, If any, Jeading to immediate Due to (or as a consequence of):		
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w requires is been sign should be	Completed by			Was an 24b. Were autopsy findings available
law re has be 2 sho	uple			autopsy prior to completion of cause of performed?
certificate ector, page		25. Was case referred to medical	1 ✓ 26.Place of Death (Check only one)	Yes 2 No 1 Yes 2 No
hysician: this certif I director,	o Be	examiner? Hospital: Inpatient 2 FR/Outpatier	Othor	5 Residence 6 Other: Scene
ding Ph 1. After t funeral	-	27. Manner of Death 28a. Date of Injury 28b. Time of One		cribe how injury occurred t shot self
To the Hospital or Atten within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street (Specify) Single Family	or To	ition (Street and Number or Rural Route Number, City own, State) nut Ave., Boonsboro, MD
To the Hos within 24 h To the Fur completely	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurrence) Medical Examiner: On the basis of examination and/or investigation.	urred at the time, date and place, and due to the ation, in my opinion, death occurred at the time.	e cause(s) and manner as stated. , date and place, and due to the cause(s)
To To	Med	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		701.011111	O.C.M.E.	September 9, 2007
ND		(accept to the state of the sta		
AD 10		30. Name and address of person who completed cause or death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Pe	nn Street, Baltimore, MD 21201	

State

Registrar

31. Date filed (Month, Day,

Secretary and the second

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32. Pagistrar's Signature

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Hagerstown Maryland

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	Examir		4a. Facility Name (If not institution,	give street and number	r)		4b. City, Town, o	or Location of Death		4c.	County of Deat	h
			Anne Arundel M				Annapol			1	nne Aru	
	Funeral Director		5. Social Security Number 432–18–8938	6. Sex 7. A 1 X M 2 ☐ F	ige (In yrs. Ia: 90	St birthday) Yrs.	If Under 1 Year Months Days	Hours Min	8. Date of Bir (Month, Da larch 2	v. Year)	917 Ark	nplace (State or Foreign untry) ansas
			Usuat Residence of Decedent					1 4	lai Cli Z	2, 1	JII AIR	ansas
	h the Marylander 28a-febow	_	10a. State 10b. County			Town or Lo						10d. tnside City Limits
	he Mi	ecto	Maryland Princ	e George's	Mitch	ellvi				10- 00		M∑XYes 2 No
	with with	Funeral Director	2317 Parkside D	rive			10f. Zip Code 20721			USA	izen of What Co	untry?
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ဖွ	or ite	Fur	1 Never Married 2 Marrie	Armed Forces 1 Yes 2 X If Yes, Give	?] No		lYes, specify Cub I□Yes 2X No		Rican, etc.)		Black, White	e, etc.
Maryland 21215-0036	72 hours after death with the Maryland "naturel", or iteme 23a or 28a-f ehow allow Examinar must be notified at	d by	3 ₩idowed 4 □ Divorced	Year or Dates	-							ack
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р	e file al Hyg l othe vent,	3e C	17. Father's Name (First, Middle, L	ast)				18. Mother's Name	(First, Middle			
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Baltimore,	permit. Pages Depertment of H important: if Ite eny injury or of		1XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		cen	netery, cren	natory or other pla nt Gardens	ce)	/2007			
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ä	99 = 9		KILL					apolis Roa				
5	Physician /Medical Examiner	- E	23a. Part1. Enter the disease, or a shock, or heart failure. List of immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions.	a	s a conseque	c Grance of):	er the mode of dyir	ng, such as cardiac c	or respiratory a	rrest,	•	Approximate Interval Between Onset and Death
68760,	certificate be executed rding physicien and use as the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	s a conseque	ence of):						
P.O. Box (death e atter d for u	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	leath 3	Ectopic pregnancy Other (specify)	y 		2	23d. Date of deli Month	very Day Year
	signed signed		Part II, Dther significant condition	ns contributing to death	but not result	ting in the ur	nderlying cause giv	ren in Part I.		obacco u Yes 2 (the cause of death?
Division of Vital Records,	The law ete has b page 2 st	Completed									death?	topsy findings available ompletion of cause of
Vita	Physician: The this certificete rat director, pag	Be	25. Was case referred to medical examiner?	Hospital:			104	26. Place of Death	(Check only o	one)		
of	Phys this at di	<u>و</u>	1 Yes 2 No 27. Manner of Death	Hospitat: 1 Inpat		R/Outpatient		4 U Nursing Hor	me 5 Resi			ufy)
on	nding th. :: After e funer	tion	1 Datural 5 ☐ Pending 2 ☐ Accident investiga		ay Year)	Injury	28c. tnjur Wor M 1	rk? Yes 2 □ No	Edd. Describe	now intuit	y occumed	
Jivis	or Attendi efter death Director: A in by the fi	Certification:	3 Suicide 6 Could no 4 Homicide determin	and 286. Place of In	njury - At hometc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (: City or To	Street and wn, State,	d Number or Ru)	ral Route Number,
_	To the Hospital or Attentwithin 24 hours efter deatl To the Funerel Director:	edical C	29a. Certifier Certifying (Check only one)	Physician: To the besi xaminer: On the basis and manner s	of examinatio	ledge, death on and/or inv	occurred at the tirestigation, in my o	me, date and place, a opinion, death occurre	and due to the ed at the time,	cause(s) date and	and manner as	stated. to the cause(s)
	within 2 To the	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date	e signed (Month	
	08)) (M)	2/			DIS	272	-	91	410	9/04/07
	XOZ		30. Name and agoress of person w	tho completed cause of	death (Item 2	23a) (Type, I	erinti)	y Annael	iz, Mb	710	107	
	Sta		31. Date filed (Month, Day, Year)	1 1 2007	tran Signatu	re A	Charle					
	Registr	ar	9/4/10 SEI	11400			7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-f per me 28/2 10/11/0/dhb 30468 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 **Physician** Month Day 09 MOSSRUSH WILLIAM 03 1630 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 **X** M 2 □ F Yrs. Director 205-01-5076 87 January 29, 1920 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examlner must be notified at Director 1 Yes 2 No Allegany Frostburg Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 65 Ormand Street "natural", or items 23a U.S.A. Funeral 21532-Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: ₩ ₩ ፲፫ 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛣 No Specify. ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) C.I.A. agent 12 U.S. Government Is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Mossrush Elizabeth Peffer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is any injury or other trau once. P.O.A. 21532-Martha Brant Frostburg Maryland 65 Ormand Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State NZ Burial 2 ☐ Cremation 3 ☑ Removal from State Arlington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) September 25, 2007 Arlington Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Post. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Immediate Cause (Final Sublens **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine CERTIFICATION APPROVED BY MEDICAL EXAMINE The law requires that the d'ath certilicate be executed and Due to (or as a consequence of) Box 68760. physician Physician/Medical attending for use as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the detached Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA ours after death.

neral Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 A I Natural 5 ☐ Pending investigation Injury Unknown **Unknown**M 1 ☐ Yes Multiple falls 2 Accident 2**7** 1No 6 □Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Unknown within 24 hours a

To the Funeral (
completely filled Unknown To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

TIRS

31. Date filed (Month, Day, Year) State SEP 06 Registrar



DHMH 17 Rev 1/2001

D14389

State

5

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

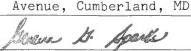
32. Registrar's Signature ▶ SEP 1 0 2007

47 Virginia

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Noshin Qaisrani, M.D.,



29d. Date signed (Month, Day, Year)

September 7, 2007

29c. License number

D0064167

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 30470 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month DONALD MCKENZIE 09 06 2007 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year)

May 06, 1926 6 50 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 🗹 M 2∏ F 215-20-5234 81 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 No Director Frostburg Maryland Allegany 10e. Street and Number 19906 National Highway, N.W. 10f. Zip Code 10g. Citizen of What Country? 21532by Funeral U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Ves 2 No If Yes, Give Year or Dates: WW T 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🟋 No 3 Widowed 4 ☐ Divorced Completed the Medical Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired)
 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) truck driver coal mining 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph McKenzie Samantha Werner ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If Item 27 is any Injury or other trains Maryland 21532-Steve McKenzie son Frostburg 11301 Savage Mountain Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1⊠Burial 2 □Cremation 3 □Removal from State Frostburg Memorial Park September 10, 2007 Frostburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Past . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ECOMPENSATED /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed as the burial-trai Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery ed by the atter 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has certificate | performed' death? 20 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

0 VA NOB

State Registrar

31. Date filed (Month, Day, Year) SEP 1 0 2007

29b. Signature and title of confifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATIONA

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30471 Certificate of Death Reg. N2 0 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month SCP Year Mary 5, Moran /Medical 06 2007 III7 A M 4a. Facility Name (It not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard HO501 6 Eneral Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 28, 1922 6. Sex 9. Birthplace (State or Foreign Country)
Wisconsin **Funeral** Months 1 □ M 2 □ F Days Hours Min. 579 14 3421 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits a or 28a-f she t be notified a Director 1 ☐ Yes Ž No MD Howard Dayton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a e Examiner must b 21036 4201 Linthicum Road United States Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14 Race - American Indian Black, White, etc. 1 □ Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White "natural", the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Clinical Psychologist State of MD of Health and Mental Hygie Item 27 Is marked other t r other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John T. Corbett Anne Walsh ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy M. Moran/Daughter 3374 N. Chatham Rd Apt F Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or otl 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 9-10-2007 4 □ Donation 5 □ Other (Specify) Suitland, MD 21. Signature of Funeral Service Licensee 7M01044 22. Name and Address of FacilitHarry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: lf yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours af

To the Funeral D

completely filled in 1 icertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number undran mo MV21044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Chyldian

32. Resistrar's Signature

10724

Patrixant

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month mme hra /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMI If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/2/1951 Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🕇 F Days Months Hours Yrs. Director 231-76-8775 56 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits a or 28a-f show t be notified at show Director 1 ☐Yes 2 TXNo Virginia | Accomack New Church 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a (Medical Examiner must b 33238 Evergreen Dr. 22415 USA Funeral 2 should be filed within 72 hours after death and Mental Hygiene. is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the 12 Cashier Resturant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Robert Kyger Ruby Morris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Nimmerichter/husband 33238 Evergreen Dr. New church, Virginia 22415 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 🗷 Removal from State Eastlawn Memorial 9/6/07 Harrisonburg, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Gardens 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 21. Signature of Funeral Belvice Excessions

(FSP Holloway Funeral Rollie FA 501 Snow Hill Rd. Salisbury)

23a. Part1. Enter the discrete, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Holloway Funeral Home PA 501 Snow Hill Rd. Salisbury, Maryland 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Stage /Medical Due to (or as a con quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transit Due to (or as a consequence of): Box 68760. attending physician þ Physician/Medical the as IF FEMALE: nse s 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) ned by the a detached f 1 ☐ Yes 2 No P.0. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, been signe should be o þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a Was an has autopsy performed? (es 2 No page certificate Division or Vital | 1∐ Yes Physiclan: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 HOther (Specify) Hospical 1 ☐ Yes 2 Tel No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: or Attending 1 De Natural 5 Pending investigation within 24 hours aren
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) SEP 0 7 2007

GREGORIO M. BELLOSO, M.D.: 5302 CHINABERRY DR., SALISBURY, MD 21901 Registrar's Signature

Name and a ress of person who completed cause of death (Item 23a) (Type, Print)

D 29505

09-03-2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30473 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 30, 2007 ear **Physician** 9:00 Olson Marjorie Ann /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6741 Aralia Avenue St. Leonard Calvert If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 74 Yrs. 8. Date of Birth (Month, Day, Year) Apr 24, 1933 5. Social Security Number Birthplace (State or Foreign
Country) **Funeral** Months Days 1 ☐ M 21 K F Virginia 579-46-7328 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at 1XYes 2 No Lake Lady Lakes Director Florida 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32159 USA 1222 Pompano Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify. þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Painting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked ပ Frank Kidd Carrie Kidd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 21403 1406 Howard Road Annapolis, MD Nancy Brown or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State Sept 7 Cheltenham, MD 4 Donation 5 Dother (Specify) Maryland Veterans 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA Gary J Goff 20736 8125 Southern Maryland Blvd. Owings. MD23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARCINOMA **Physician** 12 MON /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 38 attending p 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ res 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has death? 1 ☐ Yes 2 ☐ No perform certificate 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28b. Time of 28a. Date of Injury 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural (Month) Day Year) 5 ☐ Pending investigation 28e. Place of injury 1 Yes 2 □ No 2 Accident 6 Could not be 3 ☐ Suicide At home, farm/street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide building, etc. (Specify) To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 29a, Certifier Medical miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tit 400 37228 MD

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signatur 7 2007 SEP

MD

30. Name and address of person who completed caus-

Steven Cafferty,

Great Mills, MD

22333 Green View Parkway

of death (Item 23a) (Type, Print)

		1	For State Registrar	State of Mar		tificate of De		Reg.		
	N. 5.		1. Decedent's Name (First, Middle, La.	st)				2. Date of Death Month	Day Your	3. Time of Death
1	Physici /Medic		Robert Charle	es Procto	r				29 2007	0607 M
	Examin		4a. Facility Name (If not institution, give		2 1	4b. City, Town, or Lo	ocation of Death	1	4c. County of Death	4.
1		A ^N	13720 Old Ina	ion itead	- Koad	Brand	y wire	e Prince 6		George's
	Funeral		Social Security Number 6. S	ex 7. Age (Oxt 2 F	In yrs. last birthday)		Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthi	olace (State or Foreign ntry)
\$	Director		579~36-3398		7.6 Yrs.			Nov.8, 19	30 Wash	ington,D.C.
	and		10a. State 10b. County	1	0c. City, Town or Lo	cation	······			10d. Inside City Limits
	Mary fehc	ŏ	Maryland Charles	3	Brandyw:	ine				1 ⊋Yes 2 ☐ No
	28a	rect	10e. Sireet and Number			10f. Zip Code		10g	. Citizen of What Cou	ntry?
	3a or		13720 Old Indian	Head Rd		20613		,	Inited Sta	***
	death	Jere	11. Marital Status	12. Was Decedent Ev	er in U.S. 13. \	Vas Decedent of Hisp I Yes, specify Cuban,	anic Origin? (Spe		14. Race - Ameri	can Indian,
9	or Ite	by Funeral Director	1 ☐ Never Married 2 🙀 Married	Armed Forces? 1	,	37	Mexican, Pueno i Specify:	rican, etc.)	Black, White,	
ဗ္ဗ	ours rai'.	d b	3 Widowed 4 Divorced	Year or Dates:		10 10s 20 No .	эрөспу.		Specify:Bla	CK
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Iteme 23a or 28a-f ehow ont, I'm Mudical Each at Frank be multified at	Completed	15. Decedent's Ed (Specify only highest gra		16a. Deced	lent's Usual Occupation kind of work done during OO NOT use retired)	on ring most of workii	16l	b. Kind of Business/In	dustry
2	ne ne ne ne ne ne ne ne ne ne ne ne ne n	d E	Elementary/Secondary (0-12)	College (1-4or 5+)		oo NOT use retired) pecial Pol:			Governme	nt
7	Hygie Hygie Ther I		17. Father's Name (First, Middle, Last)	1				(First, Middle, Ma.		:IIC
and	od of	Be								
2	thould id Me mark matic	P	Horace Q. Procto		19b. Mailir	g Address (Street and		Ella Hawk LBoute Number C		Code)
S	th ac th ac 27 is trau		Manuela S. Proct	**		01d India				
5	s 1 and 2 Health Item 27 other tra		20a. Method of Disposition			sition (Name of natory or other place)			. Location - City or To	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-1 ehow any fulury or other traumatic event, If a Medical Esaciliat man be nutified at Once.		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State		ny Memoria:	1 9/5/	2007 т	and arrow	or a
≣	nit. Fortan		21. Signatyre of Funeral Service Licer	A		. Name and Address	of Facility		andover, l	
ñ	Depariment of the series of th		Pait a. L	Tured M	U ars	Alexanderin	S. Pope	e/Porestv	ille, M d	. 20747
4	*, *-		23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications hat caused the	e death. Do not ent					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Athana	1 eneti-	Cardin	mer ala	Hear	A. Dicea	
	/Medical		resulting in death)	Due to (or as a	consequence of):	Car coqui	2500		(0,3 0,2)	
Si,	Examiner		Sequentially list conditions.	b						
	D tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):					
	and trans	Kam	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	oncoguence of):					
60,	ificate be executed g physician and as the burial-transit	E		Due to (or as a t	onsaquence or).					
68760	physis the	edical	•	d						
	eath certifi attending for use as		IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of deliv	001
Box	eath cert attendin I for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 i	Fetal death 3	Ectopic pregnancy Other (specify)			Month Month	Day Year
o.	the d y the	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
J.	requires that the death cert sen signed by the attendin hould be detached for use	by Pi	Part II. Other significant conditions of	ontributing to death bul	not resulting in the ur	nderlying cause given	in Part I.	23e. Did tobac	co use contribute lo t	he cause of death?
Vital Records,	n sig							1 🗆 Yes	2 □ No 3 □ Prol	bably 4 Denknown
00	¥ 90	Completed						24a. Was an	24b. Were auto	opsy findings available
æ	The faw ate has b	E						autopsy	death?	empletion of cause of
ā		Be C	25. Was case referred to medical			2	6. Place of Death	(Check only one)	No 1 Yes	2010
	S 2	ToE	examiner?	Hospital: 1 Inpatient	2 ER/Outpatien	Othor			e 6 □Other (Specia	fy)
Division of			27. Manner of Death 1 ■ Natural 5 ■ Pending	28a. Date of Injury (Month, Day)	'ear) 28b. Time of	28c, Injury at Work?	t 2	28d. Describe how	injury occurred	
<u>S</u>	Attending or death. ector: After by the fune	atle	2 Accident investigation				s 2□No			
Ž	f or Attending Petter death. Director: After t	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury building, etc.	- At home, farm, str (Specify)	eet, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	Hospital or 24 hours efte Funeral Dir tely filled in									
	Hospital	Medical	29a. Certifier 1 Certifying Ph	ysician: To the best of a	camination and/or inv	occurred at the time, restigation, in my opin	date and place, a ion, death occurre	and due to the caused at the time, date	e(s) and manner as s and place, and due t	tated. o the cause(s)
	To the Hospital within 24 hours e To the Funeral I completely filled	Mec	29b. Signature and title of certifier	and manner state	· · · · · · · · · · · · · · · · · · ·	29c. License n	umber	29d	Date signed (Month,	Day, Year)
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	TH		30. Name and address of person who	completed cause of don	th (Item 23a) /Tuna	Print) Dri.	55 /	36	11 timber	1, -00;
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 2007 10:25 P ^M Marian V. Padgett September 6, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 5630 67th Avenue Riverdale Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 🔀 F Yrs. Aug 26, 1919 Washington, DC 88 Director 214-58-3624 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.

s marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medica Examiner must be notified at 1 XYes 2 No Director Maryland | Prince George's Riverdale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20737 USA 5630 67th Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White Completed by 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Susanna V. Rhine Reginald O. Carlisle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (daughter) 5630 67th Avenue, Riverdale, MD 20737 Darlene Pilkerton other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or ott 3 ☐Removal from State 1 ☑ Burial 2 ☐ Cremation Ft. Lincoln Cemetery 9/11/2007 Brentwood, MD 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature Funeral Service License 9013 Annapolis Road, Lanham MD 20706 23a. Paul. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death In mediate Cause (Final disease or condition resulting in death) Pulmonary Embolism **Physician** 4 weeks /Medical Due to (or as a consequence of): Examiner Pneumonia 2 days Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🔯 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed? 1 Yes 2 No certificate Physician; 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director. Be Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in death. 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ပ္ 0016410 09-10-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500 Hanover Parkway, Suite 105, Greenbelt, MD 20770 Dr. Gabriel Jaffe 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 0 2007 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Year Physician 10:12A **PURKS** EARL GOUGH SEPTEMBER 7, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1⊠M 2□F Director 215-36-3913 65 SEPT. 12, 1941 WASHINGTON. Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c, City, Town or Location show ms 23a or 28a-f show 1 ☐ Yes 2 X No Director BOONSBORO MARYLAND WASHINGTON 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 and Injury or other traumatic event, the Medical Examiner must be no once. 8846 MAPLEVILLE ROAD 21713 U.S.A.

14. Race - American Indian, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 TRUCK DRIVER TRUCKING INDUSTRY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RODERICK HANSFORD PURKS CHARLOTTE GOUGH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8846 MAPLEVILLE ROAD, BOONSBORO, MARYLAND PATRICIA PURKS/SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Spacify) SMITHSBURG CREMATORY 9/11/2007 SMITHSBURG, MARYLAND 22. Name and Address of Facility 21. Signature of Funcial Service Licensee 7606 Old NationalPike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Part 1. Enter the disease or com shock, or heart failure. List only Immediate Cause (Final Gastrointestina **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ntic ulcer Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, nding physician use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the sahould be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2. No certificate 1□ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No 1 ☐ Yes 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler 29c. License number 30. Name and address of persop who completed cause of death (Item 23a) (Type, Print) 20 FREDERICK MD HENRY 400 WEST SEVE 57, 32 Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 30477 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 2007 7:45A **Physician** September 8, Price Grace Lillie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany Cumberland Allegany Co. Nursing & Rehab Ctr. 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 02/06/1917 90 214-07-2117 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County f show 1 ☑Yes 2 ☐ No ntal Hygiene. I other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at Cumberland Allegany MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21502 220 Somerville Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 11, Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: filed within 72 hours after 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 White 2 3 □ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Completed 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Church Pastor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event Be Binnix Mary Price Η. George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13832 Briarwood Drive, LaVale, Maryland 21502 Robert C. Keech / Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cumberland, MD 09/11/2007 Hillcrest Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of un ral Service Licensee 21502 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Years <u>Severe Chronic Obstructive Lung Disease</u> Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical the as attending | for use as IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 4□Pregnant at time of death signed by the aid be detached f 1 ☐ Yes 2 🙀 No Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Severe Osteoarthritis Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 X No this certificate spital or Attending Physician: Thours after death.
Ineral Director: After this certificat y filled in by the funeral director, ps 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☒ No Certification: To 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death Injury 5 ☐ Pending investigation 1 K Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 3 ☐ Suicide 4 Homicide To the Hospital o within 24 hours aff To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie September 10, 2007 D0054004 M rosse 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221E National Highway, LaVale, Maryland Shiv C. Khanna, M.D., 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 1 2007 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

	-	Please Type or Print in Black in State of Maryland / Dep	artment of Health and Me ertificate of Death	ntal Hygiene Reg. No	2007 304/8	
Physici		Decedent's Name (First, Middle, Last) LILLIAN DIAN POOLE		Date of Death Month Da EPTEMBER	M	
/Medi Examir		4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL	4b. City, Town, or Location of Death FREDERICK	F	. County of Death REDERICK	
Funeral Director		5. Social Security Number 434-66-1048 6. Sex 1 □ M 2 □ F 7. Age (In yrs. last birthday for 10 or 10	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	B. Date of Birth (Month, Day, Year) JAN 17 1	9. Birthplace (State or Foreign Country) LA	
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or U MD FREDERICK FRED	erick		10d. Inside City Limits 1 □ Yes 2 1 No	
death with the Maryland ims 23a or 28a-f show r must be notified at	al Director	10e. Street and Number 4011 BAKER VALLEY ROAD	10f. Zip Code 21704		itizen of What Country? USA 14. Race - American Indian,	
be filed within 72 hours after death with the Marylan ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerlo R 1 □ Yes 2 No Specify:	Rican, etc.) Black, White, etc. Specify: WHITE		
be filed within 72 hours after ital Hygiene. d other than "natural", or Ite event, t <u>he Medical Examine</u>	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of working DO NOT use retired) INISTRATIVE ASSI	g	EDUCATION	
2 should be filed withing end Mental Hygiene. Is marked other than aumatic event, the M	To Be Co	17. Father's Name (First, Middle, Last) JOHN JOSEPH TEMPLE	e (First, Middle, Maiden Surname) MAE POTTS			
1 and Health em 27		JOHN E. POOLE, JR./SPOUSE 40 20a. Method of Disposition 20b. Place of Dispersion 20b. Place of Dispersion 20b. Place of Disposition 20b. Place Of D	rematory or other place)	RD., FRE	EDERICK, MD Location - City or Town, State	
permit. Pages Department of Important: If its any Injury or o		1 ☐ Burial 2 Dicremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee	R CREMATORY 9/9/ 22. Name and Address of Facility HILTON FUNERAL P.O. BOX 86, BA	HOME	FREDERICK, MD	
Physician / Medical Examinet Examinet Examinet Examinet Examinet Examinet Example Physician and Physician and Physician St. Physician Ph	al Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not eash shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Acute Car Due to (or as a consequence of):	Organ Lys Lung Cani reliae Jai	ton Fa	Approximate Interval Between Onset and Death	
w requires that the death certificate is been signed by the attending physis should be detached for use as the the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year	
quires that t n signed by	2	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.		co use contribute to the cause of death?	
The la	Completed			24a. Was an autopsy performed 1 Yes 2 ■	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No	
sician: The certificate rector, pag	B	25. Was case referred to medical examiner? 1 Tyes 2 No Hospital: 1 Inpatient 2 ER/Outpa	0.11	n <i>(Check only one)</i> me 5□ Besidence	e 6 ☐Other (Specify)	
ding Phys h. After this funeral dir	tion: To	28a Date of Injury 28b, Tim	ne of 28c. Injury at	28d. Describe how it		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)		City or Town, S		
Hospit 24 hours Funera	Medical		death occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)	
To the within? To the comple	Mec	dariusia Ifeens M	29c. License number \$2006544		Date signed (Month, Day, Year) 9/8/07	
V		30. Name and address of person who completed cause of death (Item 23a) (Ty	ype, Print) - h STREET FREDER	RICK, MD	21701	
	State istrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Aparle .			
D1001147.D	1/200		~			

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomer Grove ockville Nursing home Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) Feb, 19 Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Maryland Hours 1 □ M 2√2 F ,192d 87 Director 218-30-4644 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Gaithersburg Director MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20877 U.S.A. 7901 Spiceberry Circle, #B Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Black þ 3 □ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 7 th College (1-4or 5+) Domestic Home or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of Howard Foreman, Sr Geneva Murray 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code $2\,0\,8\,7\,7$ 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trac 7901 Spiceberry Cir. #B, Gaithersburg, MD Ethel Foreman (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Bunal /2 □ Cremation 3 □ Removal from State 9/11/07 Rockville, MD injury o Parklawn Mem Park 5 Other (Specify) 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 To not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final anglene **Physician** disease or condition resulting in death) /Medical Due to (or as a con-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl for use as t 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy perform 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: / 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainted as a control.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , F208. 225 Grove Rd 32. gistrar's Signature Day, Year) State

DHMH 17 Rev 1/2001

Registrar

6 2007

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 7 2007 7.57 A M CAROLE September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Howard County General Hospital Columbia 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🛣 F Yrs 1941 65 Dec 6, Director 219 36 1044 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐Yes 2X No Director Ellicott City MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21042 Items 23a 5002 C4 Dorsey Hall Drive Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐ Yes 2**%** If Yes, Give Year or Dates: 25 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2€ No Specify: <u>ک</u> White 3 Widowed 4 Divorced 'natural" Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Social Security Adm. 12 Administrative Assistant other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental om 27 is marked o Cecelia Ann Zelaznicki Francis Roger Hagan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 661 Sheridan St. PO Box 654 Eureka, NV 89316 <u>Michael James Protani/Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Iter
any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9-13-2007 Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Sepvice Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Carcinoma **Physician** Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Dure to for as a consequence of if any, leading to immedite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 ☐ Pregnant at time of death 9 Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Donknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed certificate 2 or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient ို After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death. hin 24 hours after death the Funeral Director: Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30641 Nek Road Baltmor Mayland 2/22, 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rawal Salardh 201-109 Back Ryvu 201-109 gistrar's Signature 31. Date filed (Month, Day, State

Registrar

DHMH 17 Rev 1/2001

Physician /Medical **Examiner** be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

the funeral director, page 2 should be after death

Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be

1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b Signature and title

29c. License number

PILE POBX1733

29d. Date signed (Month. Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year) 07

SEP

32. Registrar's Signature

State Registrar

Medical

within 24 hours a To the Funeral I

State of Maryland / Department of Health and Mental Hygiene 30482 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1945 Edward Ramsey, Sr. September 2, 2007 James /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Cumberland WMHS-Braddock Campus 8. Date of Birth (Month, Day, Year) 11/13/1927 9. Birthplace (State or Foreign Country) Pennsylvania If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 X M 2 □ F 79 Director 159-20-1470 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show 10b. County 2 should be filed within 72 hours after death with the Maryla n and Mental Hygiene. Yis marked other than "natural", or Items 23a or 28a-f shov its marked other than "natural", or Items to notified at raumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Cumberland Director MD Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 11723 Bedford Road, NE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1945 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 ☐ Divorced 1945 White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Plant Engineer Bakery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ramsey Sadie George Washington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ages 1 and 2 nt of Health a : If item 27 is or other tra 11723 Bedford Road, NE., Cumberland, MD Dorothy R. Ramsey / 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 XBurial 2 □ Cremation 3 □ Removal from State Department of Important: If any Injury or Vet. Cem @ Rocky Gap 09/07/2007 Flintstone, MD 4 □ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service License 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that cluded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the control of the control Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bronchogenic Carcinoma 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending plant of the last as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy Month Vear Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No the 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performed? 1□ Yes 2ሺ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ၉ this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After t Certification: Injury (Month, Day Year) 1 X Natural 5 Pending investigation o the Hospital or Attendir vithin 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completely filled in the completely filled in 1 \(\) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \(\) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D19318 September 4, 2007 1UA 30. Name and address of person who completed use of death (Item 23a) (Type, Print) 517 Oldtown Road, Cumberland, MD Nagaratnam A. Ranjithan, M.D., 32 egistrar's Signature 31. Date filed (Month, Day, Year) State 05 SEP Registrar

12+1

(Check only one)

29b. Signature and title of certifier

9901 Medical Center Drive, Rockville, MD 20850 Shahryar Davari, MD, Registrar's Signature - 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

29d. Date signed (Month, Day, Year)

August 28, 2007

			For State	State of Marylan	-	artment of F rtificate of I		_	giene Reg. No	Z (1 U T	30484	
C			Registrar 1. Decedent's Name (First, Middle, Lasi	1)				2. Date of De	eath		3. Time of Death	
	Physici		Carol Rai					Month August	20		6:40 a M	
-	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deat			County of Death		
			6 Titonka Court			Derwood			Mo	ntgomery		
	Funeral		Social Security Number 6. Se	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Yea <i>r)</i>	9. Birth	place (State or Foreign intry)	
L	Director		5/1-88-0499	55	Yrs.			April 9	9,19	52 Miss	ouri	
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits	
	Mary -f sho ied a	to	Maryland Montgomer	y Derv	tood.						1 ∐ Yes 2√10No	
	r 28a	Directo	10e. Street and Number	y Delv	voou	10f. Zip Code			10g. Cit	izen of What Cou	intry?	
	h with	al D	6 Titonka Court			20855			Uni	ted Stat	es	
	deat ems	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No to Rican, etc.))-	14. Race - Amer Black, White		
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏹 Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:	,,			ucasian	
င်	72 ho natui dical	eted	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo	rking	16b. K	ind of Business/l	ndustry	
7	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			d) -					
2	led w lygie her ti ht, th	ပ္ပိ	17. Father's Name (First, Middle, Last)	4	Para.	legal	18 Mother's Nar	ne (First, Middle	Maiden	Legal		
anc	ntal he fi	Be	Leon Zemliak				Ruth B1		, maraon	ourname)		
Maryland	thould mark	P	19a. Informant's Name/Relationship (T	vpe. Print)	19b. Maili	ng Address (Street			er, City o	r Town, State, Z	ip Code)	
<u>B</u>	nd 2 s Ith an 27 is trau		Ellen Tennenbaum			,				,	,	
ē,	r Hea		20a. Method of Disposition	20b. P	lace of Dispo	tonka Cou sition (Name of matory or other place	i	Date MD	2085 20c. Lo	ocation - City or	Town, State	
Ē	ent of Fig.	,	1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		coln Crem	Sent	. 1,200	7 Bre	entwood,	MD	
Baltimore,	mit. F portar injui		21. Signature of Funeral Service Licens			2. Name and Addre	ss of Facility Si	mple Tri	ibute	2	1110	
ñ	a m De		I tan In Disc	h they			10 Ro	40 Rocky ckville,	7ill∈ MD	20852	19	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death	. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory a	ırrest,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition a. Breast cancer Metastatic to bone and liver									
	/Medical Examiner		resulting in death)	Due to (or as a consequ							/ years	
	Examiner	_	Sequentially list conditions,	b	, and a file						_	
ī	ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	derice or).							
	execu al-trai	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):						-	
28/60	ificate be executed g physician and is the burial-transit	edical		d								
9	tificat ig phy as th											
Š R	death certific e attending pl d for use as t	an/N	23b. was decedent pregnant	23c. If yes, outcome pf pregna 1 ☐Live birth 2 ☐ Fetal	death 3	⊒Ectopic pregnancy	у			23d. Date of deli	very Day Year	
	he dear the at	Physician/M	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	4⊡Pregnant at time of de 9⊡Unknown	eath 5[Other (specify) _						
ī.	that t led by detar		Part II. Other significant conditions co	ontributing to death but not resu	ılting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco ι	use contribute to	the cause of death?	
ecords	w requires that the de been signed by the should be detached	d by						1 🗆	Yes 2	No 3□ Pro	obably 4 □Unknown	
000	law rec as bee 2 shou	Completed						24a. Was		24b. Were au	topsy findings available	
Ť	9 E 9	оше						auto perfe 1∐ Yes	psy ormed? 2∏ No	death?	ompletion of cause of 2 □ No	
<u>ra</u>	slcian: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Dea	ath (Check only	~~			
	Physician: r this certific ral director,	To E	examiner? 1 □ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie		4 LI Nursing F	lome 513 Resi	idence	6 □Other (Spec	oify)	
n or	ding Physician: After this certific funeral director,		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe	how inju	y occurred		
SIC	Attending r death. ector: Afte	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury - At ho	me farm et		Yes 2 □ No	28f Location (Stroot ar	d Number or Bu	ral Route Number,	
DIVISION	l or Attend after death Director:	Certification:	4 ☐ Homicide determined	building, etc. (Specify	()	oot, lactory, cinec		City or To	wn, State)	ra House rumber,	
	ospital or nours afte ineral Dir y filled in			vsician: To the best of my kno								
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exam	iner: On the basis of examina and manner stated.	tion and/or ir	ivestigation, in my o	opinion, death occ	urred at the time	, date an	a place, and due	to the cause(s)	
	To the comp	Ž	29b. Signature and title of certifier	ĺ		29c. Licens	e number		29d. Da	te signed (Month	n, Day, Year)	
}	15			Ussan		MDD00	060050		Aug	ust 30,	2007	
			30. Name and address of person who o									
			Mahrukh M. Hussain	32 Radistrar's Signa	ccard	Drive, Ro	ckville,	MD 208	50			
	Sta Registr		3EP - 6 2	007 32. Polistrar's Signa	H A	Cast o						
				A								

		For State Registrar	State of Ma	ryland / Dep. <i>Ce</i>	partment of H ertificate of L	ealth and N Death	/lental Hyg F	giene 2007	30485
Physicia	_	1. Decedent's Name (First, Middle, Las Mildred Eliza		olds			2. Date of Dea Month Septemb	Day Year	3. Time of Death 3:35 AM
/Medic Examin	er	4a. Facility Name (If not institution, give Genesis - Severna 5. Social Security Number 6. Se	street and number) Park Center ex 7. Age	er (In yrs. last birthda)	Severna	Park If Under 24 Hrs. Hours Min.	8. Date of Birtl	4c. County of Dea Anne Arun h (, Year) 9. Bir	
Director works	J.	215-22-0378 Usual Residence of Decedent 10a. State 10b. County	□ M 2¶ F	10c. City, Town or I	Location	1,000		3, 1926 Mar	* *
with the M 3a or 28a-f	I Director	Delaware New Cast 10e. Street and Number		Wilmin	10f. Zip Code			10g. Citizen of What Co	ountry?
DESILITION E. INIGITY ISING ZIZIO-UUJO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	408 Delaware Ave 11. Marital Status 1 □ Never Married 2 □ Married 3≅Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give A Year or Dates:	0	3. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	Specify: Wh	erican Indian, Ite, etc. Lite
✓ I ∠ I Ͻ - ປ. A within 72 h Ygiene. er than "natu the Medical	Completed	15. Decedent's Ed (Specify only highest gra- Elementary(Secondary (0-12)	cedent's Usual Occupa ve kind of work done of DO NOT use retired	during most of worl		Medical	/Industry		
Yiand lould be file Mental Hy narked oth	To Be (17. Father's Name (First, Middle, Last) Clayton Craig	Sur- Dried	10h Ma	iline Address (Street	Haze1	Nick1e	Maiden Surname)	Zin Codo)
ore, Iviar es 1 and 2 sh of Health and item 27 is m r other traum		19a. Informant's Name/Relationship (7 Renee Renee Renee Renee Renee Relationship (7 Renee Renee Relationship (7 Renee	/ Daughter	r 59 1	Milburn Ci position (Name of rematory or other place	rcle, Pa		Maryland 20c. Location - City of	21122
permit. Pages Department of Important: If it any Injury or o		4 □ Donation 5 □ Other (Specify 21. Signatur F F ral S e Lic	ee			ist 8, ss of Facility Cr Main Str	2007 ouch Fur eet, Nor		. Maryland [aryland21901
Physician // Medical Examiner physician and	dical Examiner	23a. Part1. Enter the disease, or component in the content of the	a. Due to (or as a b. Due to (or as a c.	e.	RENAL				Approximate interval Between Onset and Death Communication
the death certification by the attending inched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other <i>(specify)</i> _	,		23d. Date of delivery Month Day Year	
Hecords, Phe law requires that e has been signed begge 2 should be dete	ρ	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use contribute Yes 2 No 3 ☐ F	to the cause of death? Probably 4 □Unknown
VITAI HECC sician: The law r certificate has be rector, page 2 sh	e Completed	25. Was case referred to medical				26. Place of Dea	1□ Yes	psy prior to ormed? death? 2 I No 1 □ Ye	
sion or vita ending Physician: ath. or: After this certific he funeral director,	ation: To B	examiner? 1 Yes		ry 28b. Time	e of 28c. Injur	4 Nursing F		dence 6 Other (Sp how injury occurred	ecify)
DIVISION pital or Attending urs after death. eral Director: Afte	Certification:	3 Suicide 6 Could not be determined	building, etc	c. (Specify)	street, factory, office	me date and place	City or To	Street and Number or I wn, State) cause(s) and manner a	
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical	(Check only 2 Medical Exar	niner: On the basis of and manner sta	f examination and/or ated.	r investigation, in my o	opinion, death occi	urred at the time,	date and place, and de	ue to the cause(s)
10		30. Name and address of person who BRIAN C. WA	completed cause of d	eath (Item 23a) (Typ	De, Print) S KLB	RIDE RI	, BALT	more, m	nth, Day, Year) ER 5, 2007 1) 21236
Sta Regist		31. Date filed (NSEP) (Year) 20	07 Silver	ar's Signature	perte			v	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30486 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Esther V. Slyke 1329 P M 4, 2007 /Medical <u>September</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Hospital Cheverly Prince George's 8. Date of Birth (Month, Day, Year) Social Security Number Age (In yrs. last birthday, if Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 □ M 2 🖫 F 69 554-78-6716 Director Jan. 24, 1938 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical France. 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1√□Yes 2□No Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5120 Woolverton Avenue 21215 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√ ∏ No Specify: <u>გ</u> Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 3 years Elementary/Secondary (0-12) Receptionist Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Daniel Weaver Emma Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katrina A. Slyke - Daughter 5120 Woolverton Avenue Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept 14, 2007 Washington, DC Glenwood Cemetery 21. Sig Name and Address of Facility Stewart Funeral Home, Inc. Benning Road, NE Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused In shock, or heart failure. List only one cause on each live. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760 physician Physician/Medical attending IF FEMALE: If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b irector, page 2 sl 24a. Was an autopsy performed? Yes 2 No 1□ Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death Check only o e) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 Hospital: Certification: To 1 ☐ Yes npatient 🕻 2 ER/Outpatient 3 DOA this 27. Manner of Ceat Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation (Month, Day Year) Natural Accident Injury 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dil completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only onel

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

32. Registrar's Signatu

29c. License number

29d. Date signed (Month Day, Year)

a or 28a-f show t be notified at the Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 2 ral", or Items 23a Examiner must b Baltimore, Maryland 21215-0036 er than "natur, If Item 27 is marked other or other traumatic event, permit. Pages 1 and 2 shou Department of Health and M Important: If Item 27 Is mar any injury or other traumat

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

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Funeral

Director

Physician /Medical Examiner

Examiner burial-trar physician Physician/Medical attending physic for use as the t signed by the a d be detached for þ Completed page 2 s rector, Be Certification: To After this funeral Vithin 24 hours after death within 24 hours after death the 1 filled in by

The law requires that the death certificate be executed

or Attending Physician:

Division or Vital Records, P.O. Box 68760,

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licensee Kel 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION resulting in death) Due to (or as a consequence of): CORONARY ARTERY DISEASE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ACUTE RENAL FAILURE Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 21 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 Tes 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year)



Melta mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D41410

September 10

TOWSON, MARYLAND 21204

			For State Registrar	State of Ma	ryland		artmen rtificat			d Mental H		e ⊷20[17	3048
	Physicia /Medic		Decedent's Name (First, Middle, Last) IRENE VIRGINIA	SCHETRO)MPF					2. Date of Month SEPTE	D	9 20	'ear 07	3. Time of Death 9:20 P
	Examin		4a. Facility Name (If not institution, give straction of the strategy of the s	eet and number) 7. Age	(In yrs. las	st birthday)	If Under	BO 1 Year	ONSBORO	rs. 8. Date of I			HING	GTON lace (State or Foreig
ŀ	Director		Usual Residence of Decedent	1 2XF (87	Yrs.	Months	Days	Hours M	lin. MAY 1		920	MAJ	RYLAND
	ne Marylan 8a-f show ptified at	Director	10a. State 10b. County MARYLAND WASHINGTO	ON	10c. City,	Town or Lo			SBORO		10- 6	24: 14/1-		0d. Inside City Limit
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Dire	11. Martar Clatas	. Was Decedent E Armed Forces?		13.	Vas Deced	2	1713 spanic Origin? n, Mexican, Pu	(Specify Yes or uerto Rican, etc.)		14. Race -	S.A.	an Indian,
2000-	2 hours afte atural", or it cal Examin	þ	1 □ Never Married 2 □ Married 3 🏿 Widowed 4 □ Divorced 15. Decedent's Educa (Specify only highest grade of	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:		16a. Dece	1 □ Yes	al Occupa	Specify:		16b.	Specify: Kind of Busi		II TE dustry
217	ed within 7; ygiene. ier than "n t, the Medi	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		kind of work done during most of working DO NOT use retired) ETERIA MANAGER 18. Mother's Name (First, Middle, Maiden Si							SCHOOL
ylaira	should be file and Mental H marked oth umatic even	To Be	17. Father's Name (First, Middle, Last) CHARLES WILLIAM CUN 19a. Informant's Name/Relationship (Type			10h Mailir	an Addroso		GLADYS	IRENE SI	ATTH			Code
מ, אמ	1 and 2 sh Health and tem 27 is n		RUTH MULLENDORE/SIS 20a. Method of Disposition	*	20b. Plac		KELD	IN D	RIVE, E	BOONSBOR(), M/		D 2	21713
5	nit. Pages artment of I ortant: If ite Injury or or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 6 ☐ Other (Specify) 21. Signature of Fyne al Service Ligensee		BOON	NSBORO	CEM 2. Name an	ETER	Y 9/	12/2007 7606 (NSBOR Nation		MARYLAND
ă	permit. Departi Importa any Inj		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	Paul M	the death.				AL HOME	Boonsl	oro,	, Mary		Approximate Interval Between
,0070	Physician //Medical Examiner bh/sician and sthe prujal-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to for as a	tage a conseque	ence of):	ert V	rle	noni				200	Onset and Death So
O. DOA O	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	. If yes, outcome p 1□Live birth 2 4□Pregnant at 9□Unknown	2 🗌 Fetal d	leath 3□	Ectopic pr					23d. Date Mont		ery Day Year
ב יה	quires that en signed b uld be deta	þ	Part II. Other significant conditions control	buting to death bu	t not resulti	ing in the ur	nderlying c	ause give	en in Part I.					ne cause of death? nably 4 ∐Unknow
מטטרו =	The law recate has been page 2 sho	Completed							_	24a. W au pe 1∐ Ye:	topsy rformed?	P de	or to cor ath?	psy findings availab mpletion of cause of 2□ No
21 0 0 10	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. On the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	spital: 1 ☐ Inpatier 28a. Date of Injun (Month, Day	y 2	R/Outpatien 28b. Time of Injury		8c. Injun Work	er: 4 □ Nursin	g Home 5 Re 28d. Describ	esidence	6 □Other		(y)
2 2 2	tal or Atter rs after dea al Director ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju- building, etc		e, farm, str	eet, factory	, office			ation (Street and Number or Rural Route Number, or Town, State)			il Route Number,
	the Hospl hin 24 hour the Funer upletely fill	Medical	29a. Certifier (Check only one) Certifying Physic 2 Medical Examine		examinatio		vestigation	i, in my o	pinion, death o		ne, date a	and place, an	d due to	the cause(s)
J	2 %	~	29b. Signature and title of certifier Multi-firm	2			D	3 2	5 1 8			Date signed (wonth,	udy, rear)
	10		30. Name and address of person who com Robert Guedenet, M 31. Date filed (Month, Day, Year)		Wyan	nd Dri		Keedy	ysville	, Maryla	ınd	21756		
	Sta Registr		SEP 11 200	1	A	1	and s							

DHMH 17 Rev 1/2001

		•	1 - For AMEN State Registrer 9 /	D#20b 6/07 <i>I</i>	Per State AACO HE	of Mary CMH ALTH	land / D DEPT ⁽	epartmer Certificat	t of H e of L	ealth and N Death	Mental Hy	giene Reg. No.	2007	30489
-	Physicia /Medic		Decedent's Name	(First, Middle Max	, Last)	Ada		Smith			2. Date of De Month August	Day		3. Time of Death 9:58 a. M
	Examin		4a. Facility Name (If 608 Mart	i Lane				Anna	poli	Location of Death S If Under 24 Hrs.	8. Date of Bis	Anr	County of Death	del
	Funeral Director		5. Social Security No. 478-22-9 Usual Residence of	999	6. Sex 1 □ M 2 ☑ F	7. Age (In 83	(In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. [Months Days Hours Min. Male Male Male Male Male Male Male Male					31,19	924 IOW	nplace (State or Foreign untry) A
	Maryland f ahow	tor	10a. State Arizona	10b. County	ppa		cottsd							10d. Inside City Limits 1 ☐ Yes 2√2 No
	with the 3a or 28a-	Funeral Director	10e. Street and Num 6900 Eas	nber		22			Code 5253				zen of What Col	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-f ahow amy injury or other traumatic event, Ite Medical Exactinat must be notified at an once.	þ	11. Marital Status 1 □ Never Marrie 3 □ Widowed		Armed F	2√∑ No live	in U.S.	13. Was Dece If Yes, spe 1 \(\text{Yes}	cify Cuba	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	0-	14. Race - Amer Black, White Specify: Wh	
21215-0036	within 72 hou iene. than "naturi ire Medicel E	Completed	(Special Special Speci	ndary (0-12)	t grade completed	(1-4or 5+)		Decedent's Usu (Give kind of wo life. DO NOT u	ork done c	during most of work	king		nd of Business/l	ndustry
	e filed al Hygi I other vent, I	Be Co	17. Father's Name (First, Middle,						18. Mother's Nam		_		
Maryland	nould be f d Mental F narkad of natic eva	인	Eremete		nin (Time Brief)		106	Mailine Addres	_	Annie Bla		or City o	r Town State 7	in Cadal
Mai	nd 2 sh aith and 27 is r r traur		Laura Au	_	(daugl	nter)		•		Annapol:		-		,p code)
Baltimore,	Pages 1 all ment of Hee tent: If Item		4 Donation	∑ remation 5 ☐ Other (S _i		n State	cemetery	Disposition (Na v, crematory or itan Crem	other plac atory	**) Septe		Alexa	endria, Vi	rginia
Bal	Depermit Deper Impor any in		21. Signature of Eu	naval Selvice	Licensee	МО	0982			ss of Facility Adv reet, Suite				
8760,	Physician and Medical Physician and Physicia	dical Examiner	23a. Part1. Enter the shock, or heal immediate Cause (disease or condition resulting in death) Sequentially list conflicting to the cause. Enter Under Cause (Disease or that initiated events resulting in death) I	nditions,	bt	o (or as a co	nsequence o	Can			or respiratory a	arrest,		Approximate Interval Between Onset and Death
.O. Box 6	death certiff e attending ed for use as	Physician/Mec	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 ₽ 9 □ Unknown	months?		birth 2 🗆 gnant at time	Fetal death	3 □Ectopic p 5 □ Other (s				1	23d. Date of deli Month	very Day Year
s, D	9 P 9	Ď	Part II. Other signif	icant condition	ons contributing to	death but no	ot resulting in	the underlying	cause givi	en in Part I.		tobacco u Yes 2		the cause of death?
Record	The law te hes bage 2 s	Completed									24a. Was auto peri 1 Yes		prior to death?	topsy findings available completion of cause of 2 No
Vital	Physician: Th this certificete ral director, pag	Be	25. Was case reference examiner?		Hospital:] Inpatient			Oth	er:		one)		Daughters
Division of	e fe	Certification: To	1 Yes 2 27. Manner of Deat 1 Natural 2 Accident 3 Suicide 4 Homicide		g 28a. Dat (Mo gation not be 28e. Pla	e of Injury onth, Day Ye	At home, fai		28c. Injun Work 1 []		28d. Describe	5 □ Residence		
ā	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu		29a. Certifier (Check only		ig Physicien: To t	he best of m	y knowledge				, and due to the	cause(s)	and manner as	
	o tha H ithin 24 o tha F omplete	Medical	one) 29b. Signature and		and ma	inner stated.	unination and			e number	ned at the time		te signed (Monti	
	⊬ s ⊢ ŏ		> H	ound.	KSSh	15	h		0	35845	>	Augus	st 27, 2	2007
d	1444		30. Name and addr	rd K	Scha	1/2			8 Def	ense Hwy	. #201	Gambi	rills, N	Maryland
	Sta Registi		31. Date filed (Mon	sep 0		Registrar's	Signature	Sour	الع					

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: All completely filled in by the fu Hospital

P 5/IVA nus

29b. Signature and title of certifier worsockslin

29c. License number D0055325

Frosthurg

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

06,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WONSOCK SHIN MD 48 TOWN Terrace

31. Date filed (Month, Day, Year) SEP 07

29a. Certifier

(Check only one)

Medical

strar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygien ? 30491 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 2, 2007 **Physician** 9:30 AM Viola Shaffer Elsie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany Cumberland The Lions Center If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1□M 2**X**F Director 189-36-0872 3-19-1922 DA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County is marked other than "natural", or Items 23a or 28a-f sho sumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** Bedford Hyndman 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 15545 USA 3705 Hyndman Rd 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygiei Important: If item Z7 is marked other tt any injury or other traumatic event, th Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Melvin E. Shroyer <u>Lillian I. Holler</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kenneth P. Shaffer Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Hyndman, PA 15545
Date 20c. Location - City or Town, State 1 KBurial 2 ☐ Cremation 3 KRemoval from State Hyndman Cemetery: 9-6-07 Hynama,
22. Name and Address of Facility Harvey H. Zeigler Funeral
15545 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Home 169 Clarence St. HundmanPA 15545 23a. Part1 Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive /Medical Due to (or as a consequence of): **Examiner** urm onasy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DYSAMMTHM 1/4 1 Yes 2 No 3 Probably 4 Nhknown Completed RENAL DW SUFFICIENCE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? es 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walsh Rd. Cumberland, MD 21502 Sidhu, MD Bishop 925 MIS 31. Date filed (Month, Day, Year) State SEP 0 6 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 09 08 2007 1445 DOROTHY V. SHAFER - MATHEWS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY CUMBERLAND MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 87 Director 220-10-9312 09/15/1919 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10b. County 10a. State 28a-f show must be notified at Cumberland MD Allegany 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or USA 21502 509 Conrad Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 'natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important; if item 27 is marked other than 'a may injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sherry Aline Wagner Margaret Η. Peter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 727, Cumberland, MD 21501 Cheryl S. Blake / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 109/11/2007 Cumberland. MD Hillcrest Mem. Park 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, 21. Signature of Funeral Service Licensee 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that course the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION Physician PNEUMONIA /Medical Examiner ESPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by RENAL INSUFFICIENCY 1 🗌 Yes 2 No 3 Probably 4 Unknown FIBRILLATION, CHF 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform DORTO STENOUS 1☐ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2[XNo 1 Inpatient 3□ DOA 2 ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064167 UT 4 ske 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 47 VIRGINIA AVE, CUMBERLAND, MD 21502 NOSHIN QAISRANI SEP 1 0 2007 31. Date filed (Month, Day, Year) State Delle Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** September 5, 2007 9:15 P Lyle E. Schucker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Golden Living Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X** F 209-20-8968 94 30, 1913 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2X No Maryland Frederick Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4508 Skyline Drive 21703 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Yes X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify: White Completed by 3 ☐Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) filed withir Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Railroad Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: if item 27 is marked o any injury or other traumatic eve Almon Snyder Rae Smoyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4510 Skyline Drive, Frederick ,MD 21703 Patricia George / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 9/7/2007 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) Stauffer Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home Þ 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ATHERO Sciences Coronmy Arthury Disense Immediate Cause (Final disease or condition resulting in death) **Physician** HYPERITE WSIVE /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 No Nown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy 2 X No 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 1 Tes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2[XNo ပ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury at Work? Injury 5 Pending investigation 1 XNatural 1 ∏ Yes 2 ∏ No M 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0047951 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOLL HOUSE AVE. FREDERICK 814 SIBTE A. KAZMI, MO 32. Registra's Signature 31. Date filed (Month, Day, Year) State

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Registrar

2007 ▶

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DHMH 17 Rev 1/2001

State Registrar Christopher J. Duke, M.D.

31. Date filed (Month, Day Year)

32. Restrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician September 5, 2007 Frances B. Snyder /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** National Lutheran Home Rockville Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 F Yrs Mar. 17, 1917 Pennsylvania 90 Director 211-10-0544 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. important: if item 27 is marked other then "netural; or items 23e or 28e-f ehow any lury or other treumatic event, the Madical Examination and the routilied at once. 1.□Yes 2□No Maryland Rockville Montgomery Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9701 Viers Drive 20850 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Years Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dora Brook Simon Friedman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8019 Summer Mill Court, Bethesda, Maryland 20817 Daniel C. Snyder - Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Beth Sholom Cong. 20c. Location - City or Town, State 20a Method of Disposition 1 Durial 2 □ Cremation 3 □ Removal from State Capitol Heights, Md. 9/6/2007 4 □Donation 5 □Other (Specify) ^{22. Name and Address of Facility} Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 21. Signature of Funeral Service Licensee 20852 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac gr respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine inding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical ettending | IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death signed by the et d be detached fo 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 A No 3 Probably 4 □Unknown 1 🗌 Yes peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an page 2 s certificate 24 No 1 Yes or Attending Physician: After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 TYes 2 NO 1 Innatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 CMatural 5 Pending after death.

Director: Aft
I in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours after of To the Funeral Directorn Completely filled in by 4 Homicide To the Hospital f 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License numbe 29b. Signature and title of certifier 30. Name and address, of person who completed cause of death (Item 23a) (Type, Print) Charles Karesh, W. MD Roc 20 WW 0 Year) 31. Date filed (MorSEP agistrar's Signature State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 30496

,,		- For State egistrar	Certificate	of De	ath		Reg	g. No.	01 0043
Physiciar ledical Examin	/	Decedent's Name (First, Middle,Last)	heen				2. Date of Death Month September	Day Year 3, 2007	3. Time of Death 0905 hrs
_	4	4a. Facility Name (if not institution, give street and number) 26935 Nanticoke Road		Sa	y, Town, or Lo lisbury		in a machin	4c. County of De Wicomico	
Funeral Director		216-70-5374 1X M 2 F 4	yrs. last birthda		Inder 1 Year Inths Days	Hours	8. Date of Birth Min. 04/16	1960 9.1	Birthplace (State or eign Cou Maryland
Aaryland 28a-f show any 1 at once		Maryland Wicomico	. City, Town or L	ury					10d. Inside City Limits 1 Yes 2 X No
th the Mary 23a or 28a-notified at	2	10e. Street and Number 26935 Nanticoke Road		10f.	Zip Code 21801		. 10	g. Citizen of What C	ountry? .
after death wi	by Fune	11. Marital Status 1 Never Married 2 X Married 1 Never Married 2 X Married 2 X Married Forces? 1 Yes 2 X 1 Yes 3 Yes 3 Yes 3 Yes 3 Yes 3 Yes 3 Yes 3 Yes 3 Yes 3 Yes 3 Yes 3 Yes 3 Yes 4 Yes 3 Yes 4 Yes 3 Yes 4	No .	If Yes, sp	edent of Hispa ecify Cuban, M 2 X No ual Occupation	white si/Industry			
	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	duri		working life. D			The state of the s	Construction
C 3 2 4 2 1	Re	17. Father's Name (First, Middle, Last) John Raymond Shaheen				Ann	lame (First, Middle, M Thorne		1,
MD 21 d 2 should th and Me n 27 is man turnatic ev		19a. Informant's Name/Relationship (Type, Print) Dawn Marie Shaheen/wife	2	26935	Nantic	oke R	d., Salisk	ber, City or Town, St	1801
Baltimore, MD 2 permit; Pages 1 and 2 should Department of Health and M Important: If item 27 is in Injury or other traumaire		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	20b. Place of D Springn Garde	isposition (or other plant IIII I	Name of ceme ace) lemory		Date 9/7/07	20c. Location - City Hebron,	
Balti permit Departit Importa	4	21. Sign ture of Funeral Service Licensee	ESP	22. HOI 501	Toways Snow	tünera Hill I	al Home Pr Rd., Salis	ofessiona bury, MD	l Association 21804
Physician /Medical xaminer		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause 23a. Part I. Enter the disease, or complications that caused the acuse on each line. 3a. Hypertensive Ather Due to (or as a consequence cause. Enter Underlying Cause c.	rosclerotic C ence of):			1500 1000		ss, snock, or near	Approximate Interval Between Onset and Death
760, icate be executed physician and the burial - transit	Medical Exa	(Disease or injury that initiated events resulting in death) Last UNPENDED Due to (or as a conseque d.	ence of):						
certif		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live birth 4 Pregnant at time 9 Unknown	2	Fetal de		Ectopic pr	regnancy	23d. Date of deli Month	very Day Y ear
, P.O. Boy	2	Part II. Other significant conditions contributing to death bu	t not resulting in	the under	ying cause giv	ven in Part I			to the cause of death? Probably 4 Unknown
of Vital Records, P ng Physician: The law requires t Mer this certificate has been sign meral director, page 2 should be o	Completed						24a. Was a autop perfor	sy prior rmed? death	
tal Rec	å	25. Was case referred to medical examiner?	0 FD/0to	-Nome 2		thor:	lursing Home 5	Residence 6 ✔ 0	thor: Scono
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	ation: To	1 Ves 2 No Inpatient 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		atient 3 _ ne of Injury	28c. Injury		28d. Describe	now injury occurred	aren. Scene
Division pital or Attendiours after death. reral Director: Afilled in by the fi	Certification:	3 Suicide 6 Could not be determined (Specify)	- At home, farm	, street, fac	ctory, office bu	ilding, etc.	28f. Location (5 or Town, S		Rural Route Number, City
To the Hos within 24 h To the Fun completely	ā	29a. Certifier 1 Certifying Physician: To the set of my kn one) 2 Medical Examiner: On the sets of examinar and manner and manner stated.	owledge, death ation and/or inve	occurred a estigation, i	n my opinion,	death occur	e, and due to the caus rred at the time, date	and place, and due t	o the cause(s)
10	Σ	29b. Signature and title of certifief			29c. License O.C.N			September 4,	
Eur		30. Name and address of person who completed cause of death David Fowler M.D. Chief Medical Examine	r 111 Per	n Stree	t, Baltimore	e, MD 21	201		
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's S	Signature	,					
DHMH 17 Rev 1/20		Color Colors	ORIZ	INAL	1				

			For State	State of	Marylan	-	artment of F		Mental Hy	0.0	07.0010
×			Registrar 1. Decedent's Name (First, Middle, I	ast)			inicale of	Dealli	2. Date of De	Reg. No.	3. Time of Death
5	Physic /Medi		EMMA :	L. TWYI	MAN				Month Sept		ear
	Examir		4a. Facility Name (If not institution, g				4b. City, Town, o	r Location of Dea		4c. County of	0 - 0 0
		4%	Millenium H				Silve	r Spri		Montge	omery
110	Funeral Director		215-62-5494	Sex 1 □ M 2 1 F	7. Age (In yrs. 7.		If Under 1 Year Months Days	If Under 24 Hr Hours Mir	8. Date of Bir (Month, Date Apr.	26,1936	Birthplace (State or Foreign Country) Maryland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation			-	10d. Inside City Limits
	Mary a-f sh fied a	tot	MD Ba	ltimore		E	Baltimor	re			1 □ Yes 2√ No
	h with the 3a or 28a st be noti	al Director	10e. Street and Number 1803 Thornb	erry Ro	ad		10f. Zip Code 212	209		10g. Citizen of Wha	s . A .
980	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 → Never Married 2 → Married 3 → Widowed 4 → Divorced	12. Was Deced Armed For 1 Yes If Yes, Give Year or Da	ces? 2[]x No e		Nas Decedent of H f Yes, specify Cuba l □ Yes 2 X No		Specify Yes or No erto Rican, etc.)		American Indian, White, etc. Black
5-0	72 hc 'natui dical	eted	15. Decedent's (Specify only highest of	Education grade completed)	,	16a. Deced	lent's Usual Occup	ation during most of w	orkina	16b. Kind of Busin	ess/Industry
Maryland 21215-0036	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12) 7th	College (1-	4or 5+)	1	kind of work done of NOT use retired nemploye			Home	
and	be file	æ	17. Father's Name (First, Middle, La George Nail							, Maiden Surname)	-
ž	should by	ဥ	19a. Informant's Name/Relationship			19h Mailin	a Address (Street			ne Twyma	tte, Zip Code) 20877
Ma	nd 2 saith ar 27 is r trau		George Nailo		her)						ersburg,MD
Je,	es 1 and 2 should to of Health and Ment fitem 27 is marked rother traumatic e		20a. Method of Disposition		0	Place of Dispo	sition (Name of	ce)	Date	20c. Location - City	
Ĕ	nit. Pages artment of I ortant: If its Injury or or		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	cify)	Riv	/erdal	le Park	Cre 9	/6/07	Riverda	
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service	offisee Mar	wke	22	Name and Addres	ss of Facility S ashingt	on St,	Rockvill	HOME, P.A. e,MD 20850
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	inplications that cally one cause on ea	used the death	n. Do not ente	er the mode of dyin	ig, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition resulting in death)	_a C	ongest	ive E	Heart Fa	ailure			Onset and Death
1	/Medical Examiner		resulting in death)		or as a consequ						
Н	-	er	Sequentially list conditions,		yperte		1				
	outed id ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	. D:	iabete	es Mel	litus				
Ö,	e exerian ar		resulting in death) Last	Due to (o	r as a consequ	uence of):					
8760,	icate be executed physician and the burial-transit	dical	•	d							
P.O. Box 6	The law requires that the death certific te has been signed by the attending f age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ※ No 9 □ Unknown		th 2 ☐ Fetal int at time of de	death 3	Ectopic pregnancy Other <i>(specify)</i>	,	23d. Date of Month	f delivery Day Year	
	s that ned by deta	by Ph	Part II. Other significant conditions	contributing to dea	ath but not resu	ulting in the un	derlying cause give	en in Part I.	23e. Did t	obacco use contribu	te to the cause of death?
ğ	w requires tha been signed I should be det	ed b	Pneumonia						1 🗆	Yes 2□No 3□	Probably 4 Munknown
Division or Vital Records,	The law recate has be page 2 sho	Completed							24a. Was auto perfo 1□ Yes	psy prior deat	
/ita	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?					26. Place of De	eath Check only o	2 ⅓ No 1 □	res ZIINO
7	% ∞ ≒	은	1 Yes 2 No			ER/Outpatient		4 Lagrursing		dence 6 Other (Specify)
on (Attending Physician: r death. ector: After this certific. by the funeral director.	ion	27. Manner of Death 12 Natural 5 ☐ Pending 2 ☐ Accident investigati		, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗀 '	yat ⟨? Yes 2 □ No	28d. Describe	how injury occurred	
/isi	Attender death	ficat	3 Suicide 6 Could not	be 28e. Place o	of injury - At ho	me, farm, stre	et, factory, office	1es 2 140	28f. Location (Street and Number o	r Rural Route Number,
ă	al or safter	Certification:	4 ☐ Homicide determine	building	g, etc. (Specify	′)			City or To		Transfer Tourist Transfer,
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral or	Medical (29a. Certifier 1 ★Certifying F (Check only one)	hysician: To the base	sis of examinat	wledge, death tion and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	To th vithir To th comp	Me	29b. Signature and title of certifier				29c. License			29d. Date signed (M	fonth, Day, Year)
	*/		Snew	aug.		()	1)14	1876		9.5.	07
	7		30. Name and address of person who Suresh Gupt					Rocky	ille MT	20852	
	Sta		31. Date filed (Month, Day, Year)	32.	nistrar's Signat	ture		1.001.V		20002	
	Registr	ar	SEP - 6 2	.007	ever to	K Ap	exist.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30498 1 - State Registrate D#19a, perFH, 9/7/07, DPS, MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** $\mathcal{N}_{\mathsf{A}_\mathsf{th}}$ 123 M Francis Paul Taxweiler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 18 M 2 □ F 206-16-4534 81 March 18, 1926 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☑ Yes 2 ☐ No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3402 Pennsylvania Street 20783 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: 2 Specify. 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Technician Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Taxweiler Gertrude Duakee မ 19a. Informant's Name/Relationshi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys Taxweiler, Wife 3402 Pennsylvania Street, Hyattsville, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 9/15/2007 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) RED ABDO MINAL AURTIC Due to (or as a consequence of): NE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner e to (or as a consequence of Due to (or as a consequence of): Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ REMAL 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed SMRATORY 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No performed. res 2 No 1□ Ý 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) No No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. May er of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **Natural** Injury 1 ☐ Yes 2 ☐ No 2 Accident

/Medical Examiner The law requires that the death certificate be executed burial-trar attending physician for use as the buria signed I I be det

Records, P.O. Box 68760,

Division or Vital

Funeral

Director

the Maryland r 28a-f show notified at

Pages 1 and 2 should be filed within 72 hours after death with trent of Health and Mental Hygiene.
snt: If Item 27 is marked other than "natural", or items 23a or 2 ury or other traumatic event, the Medical Examiner must be n

Department of H Important: If ite any Injury or ot

Physician

Baltimore, Maryland 21215-0036

5 Pending investigation 6 ☐ Could not be determined 3 Suicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 \ Homicide

🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature e of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and

7600 Carroll Ave., Takoma Park, Maryland 20912

State Registrar

Medical



Place of injury - At home, farm, street, factory, office building, etc. (Specify)

To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral to

12

Attending

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2007 xeptember /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore Hookins Hospital Johns If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number (In yrs. last birthday) **Funeral** Days Months Hours 218-34-3000 1 M 2□F JUNE 25, 1940 MARYLAND Director 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show iny or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a State 1 Yes 2 □ No Completed by Funeral Director 10g, Citizen of What Country? 10e. Street and Number 5930 TED STATES

14. Race - American Indian, Oxbridge UNITED 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: BIACK Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) TRUCKING College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RANCES ပ္ 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code)
5930 DX61198 BR
SALISHUZY, MARYLAND 21801 Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Imp_rtant; If item 27 is
any_riury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hebron, Maryland W. Isabella Street Spring Hill Memory Garden
22. Name and Address of Facility
Bennie Smith -10-0 4 Donation 5 ☐ Other (Specify) of Funeral Strice Lice Approximate Interval Between Onset and Death Salisbury Maryland FUNERAL Home plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final 0 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaint Cause (Disease or injury that initiated events resulting in death) Last Due (o) as a consequence of) Examine and burial-trar Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical IF FEMALE: asn If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for L in the past 12 months? Day 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 🔼 No has 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2**X** No 1 ☐ Yes Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

2h

State Registrar 31. Date filed (Month, Day, Year) SEP 0 7 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

shas Hospital 600 North Wolfe Street 2. Registrar's Signature Marie A Aparle

				1 - State Registrar	ate of Maryla	nd / D	epartmen Certificat	t of H e of L	ealth and I Death	Mental Hygie	ene 2007	30500
	-	Physic /Medi		Decedent's Name (First, Middle, Last) Dorothy Janet	Umstad					2. Date of Death), 2007 Year	3. Time of Death 4:40a. M
		Exami		4a. Facility Name (If not institution, give stree Williamsport Nur	sing Hom				Location of Death	_	4c. County of Deat Washin	
5	100	Funeral Director		5. Social Security Number 220-30-3699 6. Sex 1 M	7. Age (In yr. 76		rs. If Under	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Dec . 1	(ear) 1930 9. Bin	hplace (State or Foreign
		Maryland -f show	tor	10a. State MD Washingto	n W	ity Town	or Location amspor	t				10d. Inside City Limits 1√2 Yes 2 □ No
		death with the Maryland ms 23a or 28a-f show Imust be notified at	al Direc	10e. Street and Number 154 Artizan St.			10f. Zip	Code 2179	95	10ç	g. Citizen of What Co	ountry?
20/01	9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or itsms 23a or 28a-1 show any injury or other traumatic svent, the Medical Examiner must be notified as once.	d by Funeral Director	1 Never Married 2 Married 1	Vas Decedent Ever in timed Forces? ☐ Yes 2 ☑ No Yes, Give ear or Dates:	U.S.	13. Was Deced If Yes, spec		spanic Origin? (S n, Mexican, Puert Specity:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
16	Maryland 21215-003	d within 72 h giene. er than "natu r tre Medical.	Completed	15. Decedent's Educatio (Specify only highest grade con Elementary/Secondary (0-12) 11th grade	n npleted) College (1-4or 5+)	(Decedent's Usua Give kind of wo life. DO NOT us HOMEM	rk done d se retired)	uring most of wor	king	Sb. Kind of Business/ residen	
4 40 mg	yland	ould be file Mental Hy arked oth	To Be (17. Father's Name (First, Middle, Last) Talbot Clinton E					Franc	ne (First, Middle, Ma es M. Ha	aney	
•	, Mar	and 2 shu eelth and m 27 is m			on			-			City or Town, State, 2 Lng, MD	Zip Code) 21722
	Baltimore,	Pages 1 Iment of H tant: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remort 4 ☐ Donation 5 ☐ Other (Specify)	val from State	cemetery,	Disposition (Name of the Paragram)	ther place	Sep Cem 20	T 1 4	Baltimor	
Stad	Bal	Departiment Important Impo		21. Signature of Funeral Service Licensee	Liny		Donal	3 0	Burin Th	ompson I	Funeral 1	Home,Inc 1722
5.4		Physician /Medical		23a. Part1. Enter the disease, or complication shock, or head failure. List only one call Immediate Cause (Final disease or condition resulting in death)		ailu	ite	e of dying	, such as cardiac	or respiratory arrest	, 5,	Approximate Interval Between Onset and Death
Janet U	8760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Einter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Diabetes Due to (or as a conse	Mediuence of)	211,445					manyyear
orothy	P.O. Box 6	the death certifi y the attending I iched for use as	Physician/Me	in the past 12 months?	yes, outcome of pregr □Live birth 2 □ Fel □Pregnant at time of □ Unknown	al death	3 ☐ Ectopic pro				23d. Date of deli Month	very Day Year
A		quires that in signed b uld be deta	מ	Par II. Other significant conditions contribut Parkinson's Diseas		sulting in th	he underlying ca	ause give	n in Part I.		cco use contribute to	the cause of death?
	Division of Vital Records,	ysician: The law requir is certificete hes been si director, page 2 should	Completed	Dementia related	to Cereb	rova	scular	Dis	ક રહ્ય કહ	24a. Was an autopsy performe	d? prior to death?	topsy findings available comptetion of cause of
	Vita	ician: Th certificete rector, pag	Be	25. Was case referred to medicat examiner?	al·					th (Check only one)		
	o	r this	2	1 162 5 BINO	1 □ Inpatient 2 □	28b. Tim			4 Winursing Ho	ome 5 Residence 28d. Describe how	e 6 ☐Other (Spec	cify)
	ion	nding f th. :: After e funer	tion	1 Natural 5 Pending 2 Accident Investigation	a. Date of Injury (Month, Day Year)	Inju	Iry M	3c. Injury Work′ 1 □ Y	es 2 🗆 No		injury occurred	
	Divis	To the Hospital or Attandi within 24 hours after death. To the Funers! Director: A completely filled in by the fi	Certification:	3 Suicide 6 Could not be	e. Place of Injury - At I building, etc. (Spec	nome, farm	n, street, factory	, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	·	To the Hospi within 24 hou To the Funer completely fill	Medical	29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner: Cartifying Physician 2 Medical Examiner: Car	i: To the best of my kn In the basis of examin and manner stated.	owledge, o ation and/o	death occurred a or investigation,	at the time in my opi	e, date and place, nion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	24	10 S T T T T T T T T T T T T T T T T T T		29b. Signature and title of certifier Cype No. Kutt	ner-Sa	rds.	no -		451	Se	Date signed (Month	10,2007
		5		30. Name and address of person who complete Cynthia Kuther San	ds, MD W.II	m 23a) (Ty	rpe, Print)	יויבוז)	g Home,	154 Nort	h Artiza	in Street
		Sta Registr	TG.	31. Date filed (Month, Day, Year) SEP 1 1 2007	32. A gistrar's Sign	ature	L.d.	~.		-	J	